96TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
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HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS, 1979

SEPTEMBER 5, 1979.—Ordered to be printed

Mr. STAGGERS, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany S. 544]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 544) to amend titles XV and XVI of the Public Health Service Act to revise and extend the authorities and requirements under those titles for health planning and resources development, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment insert the following:

SHORT TITLE; REFERENCES TO PUBLIC HEALTH SERVICE ACT; AND TABLE OF CONTENTS

SECTION 1. (a) This Act may be cited as the "Health Planning and Resources Development Amendments of 1979".

(b) Whenever in this Act (other than in subsections (j) and (k) of section 115 and subsection (a) of section 128) an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

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TITLE I—REVISION OF HEALTH PLANNING AUTHORITY

REVISION AND REPORTING ON NATIONAL GUIDELINES FOR HEALTH PLANNING

Sec. 101. (a)(1)(A) Section 1501 is amended (i) by striking out "and shall, as he deems appropriate, by regulation revise such guidelines" in subsection (a), and (ii) by adding after subsection (c) the following:

"(d) The Secretary shall, on an annual basis, review the standards and goals included in the guidelines issued under subsection (a). In conducting such a review, the Secretary shall review the health systems plans and annual implementation plans of health systems agencies and State health plans. If the Secretary proposes to revise a guideline issued under subsection (a), he shall make such revision by regulations promulgated in accordance with section 553 of title 5, United States Code.

"(e)(1) The Secretary may collect data to determine whether the health care delivery systems meet or are changing to meet the goals included in health systems plans under section 1513(b)(2) and State

health plans under section 1524 and to determine the personnel, facilities, and other resources needed to meet such goals. The Secretary shall prescribe (A) the manner in which such data shall be assembled and reported to the Secretary by health systems agencies, State, health planning and development agencies, and other entities, and (B) the definitions which shall be used by such agencies and entities in assembling and reporting such data.

"(2) The Secretary shall from the data collected under paragraph (1) periodically make public a (A) statement of the relationship between the goals contained in the health systems plans and the State health plans and the status of the supply, distribution, and organization of health resources with respect to which such goals were established, and (B) summary of changes (either through additions or reductions) in resources needed to meet such goals.".

(B) The amendments made by subparagraph (A) do not authorize the enactment of new budget authority before October 1, 1979.

(2) Subsection (b)(1) of section 1501 is amended by adding at the end thereof the following: "Such standards shall reflect the unique circumstances and needs of medically underserved populations in isolated rural communities.".

(3) Subsection (c) of section 1501 is amended by striking out "In issuing guidelines under subsection (a) the Secretary shall" and inserting in lieu thereof "At least 45 days before the initial publication of a regulation proposing a guideline under subsection (a) or a revision under subsection (d) of such a guideline, the Secretary shall, with respect to such proposed guideline or revision,".

(b)(1) Section 1513(b)(1) is amended by adding after and below subparagraph (F) the following:

"The agency shall also assemble and report to the Secretary such data (including data on the personnel, facilities, and other resources needed to meet the goals set forth in the agency's health system plan) as the Secretary may require to carry out his responsibilities under section 1501(e). The Secretary may not require the assembling and reporting of data under this paragraph which is regularly collected by any entity of the Department of Health, Education, and Welfare under a provision of law other than this title.".

(2) Section 1522(b)(10) is amended by inserting after "require the State agency to" the following: "(A) assemble and report to the Secretary data (other than data which is regularly collected by any entity of the Department of Health, Education, and Welfare under a provision of law other than this title) which the Secretary may require to carry out his responsibilities under section 1501(e), including data on the personnel, facilities, and other resources needed to meet the goals set forth in the State health plan, and (B)".

NATIONAL HEALTH PRIORITIES; NATIONAL COUNCIL ON HEALTH PLANNING AND DEVELOPMENT

SEC. 102. (a)(1) Section 1502 is amended by adding at the end the following:

"(12) The identification and discontinuance of duplicative or unneeded services and facilities.

"(13) The adoption of policies which will (A) contain the rapidly rising costs of health care delivery, (B) insure more ap-

propriate use of health care services, and (C) promote greater efficiency in the health care delivery system.

"(14) The elimination of inappropriate placement in institutions of persons with mental health problems and the improvement of the quality of care provided those with mental health problems for whom institutional care is appropriate.

"(15) Assurance of access to community mental health centers and other mental health care providers for needed mental health services to emphasize the provision of outpatient as a preferable alternative to inpatient mental health services.

"(16) The promotion of those health services which are provided in a manner cognizant of the emotional and psychological components of the prevention and treatment of illness and the maintenance of health.".

(2) Section 1502(9) is amended by inserting before the period the following: "and the development and use of cost saving technology".

(b) Section 1503(b)(1) is amended (1) by striking out "fifteen" and inserting in lieu thereof "twenty"; (2) by inserting "the Assistant Secretary for Rural Development of the Department of Agriculture," after "Defense,"; (3) by striking out "not less than five shall be persons who are not providers of health services" and inserting in lieu thereof "not less than eight members shall be persons who are not providers of health care and those members shall include individuals who represent urban and rural medically underserved populations"; and (4) by inserting "not less than one member shall represent hospitals," after "Federal Government,".

THE ROLE OF COMPETITION IN THE ALLOCATION OF HEALTH SERVICES

SEC. 103. (a) Section 1502(a) is amended by adding after paragraph (16) (added by section 102(a)) the following new paragraph:

"(17) The strengthening of competitive forces in the health services industry wherever competition and consumer choice can constructively serve, in accordance with subsection (b), to advance the purposes of quality assurance, cost effectiveness, and access.".

(b) Section 1502 is amended (1) by inserting "(a)" after "1502.", and (2) by adding at the end the following:

"(b)(1) The Congress finds that the effect of competition on decisions of providers respecting the supply of health services and facilities is diminished. The primary source of the lessening of such effect is the prevailing methods of paying for health services by public and private health insurers, particularly for inpatient health services and other institutional health services. As a result, there is duplication and excess supply of certain health services and facilities, particularly in the case of inpatient health services.

"(2) For health services, such as inpatient health services and other institutional health services, for which competition does not or will not appropriately allocate supply consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the exercise of their functions under this title take actions (where appropriate to advance the purposes of quality assurance, cost effectiveness, and access and the other purposes of this title) to allocate the supply of such services.

"(3) For the health services for which competition appropriately allocates supply consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the performance of their functions under this title give priority (where appropriate to advance the purposes of quality assurance, cost effectiveness, and access) to actions which would strengthen the effect of competition on the supply of such services.".

(c) Section 1513(a) is amended (1) by striking out "and" at the end of paragraph (3), (2) by inserting "and" at the end of paragraph (4), and (3) by adding after paragraph (4) the following:

"(5) preserving and improving, in accordance with section 1502(b), competition in the health service area,".

(d) Section 1532(c) is amended by adding at the end the following:

"(11) In accordance with section 1502(b), the factors which affect the effect of competition on the supply of the health services being reviewed.

"(12) Improvements or innovations in the financing and delivery of health services which foster competition, in accordance with section 1502(b), and serve to promote quality assurance and cost effectiveness.".

DESIGNATION OF HEALTH SERVICE AREAS

SEC. 104. (a)(1) Section 1511(b)(4) is amended to read as follows:

"(4) The Secretary shall review on his own initiative or at the request of any Governor or designated health systems agency the appropriateness of the boundaries of the health service areas established under paragraph (3) and, if he determines that—

"(A) the boundaries for a health service area no longer meet the requirements of subsection (a), or

"(B) the boundaries for a proposed revised health service area meet the requirements of subsection (a) in a significantly more appropriate manner in terms of the efficiency and effectiveness of health planning efforts.

he shall revise the boundaries in accordance with the procedures prescribed by paragraph (3)(B)(ii). If the Secretary acts on his own initiative to revise the boundaries of any health service area, he shall consult with the Governor of the State or States which would be affected by the revision, the chief executive officer or agency of the political subdivisions within such State or States, and the designated health systems agency or agencies and the established Statewide Health Coordinating Council or Councils that would be affected by the revision. A Governor may request a revision of the boundaries of a health service area only after consultation with the Governor of any other State or States that would be affected by the revision, the chief executive officer or agency of the political subdivisions within such State or States, and the designated health systems agencies and the established Statewide Health Coordinating Council or Councils that would be affected by the revision and shall include in such request the comments concerning the proposed revision made by such individuals and entities. A designated health systems agency may request a revision of the boundaries of its health service area only after con-

sultation with the Governor of the State or States that would be affected by the revision, the chief executive officer or agency of the political subdivisions within such State or States, the Statewide Health Coordinating Council of such State or States, and the health systems agencies that would be affected by the revision and shall include in such request the comments concerning the proposed revision made by such individuals and entities. No proposed revision of the boundaries of a health service area shall comprise an entire State without the prior consent of the Governor of such State. In addition, for each proposed revision of the boundaries of a health service area, the Secretary shall give notice and an opportunity for a hearing to all interested persons and make a written determination of his findings and decision.".

(2) Not later than one year after the date of the enactment of this Act the Secretary shall by regulation prescribe criteria for the revision of health service area boundaries under section 1511(b)(4) of the Public Health Service Act (as amended by paragraph (1)).

(b) Section 1511(c) is repealed.

(c)(1) Section 1536(a) is amended by inserting "the Commonwealth of Puerto Rico," before "the Virgin Islands".

(2) Section 1531(l) is amended by striking out "and the Commonwealth of Puerto Rico".

DESIGNATION OF HEALTH SYSTEMS AGENCIES

SEC. 105. (a) Section 1515(b)(4) is amended by striking out the last sentence and inserting in lieu thereof: "In considering such applications, the Secretary shall give priority to any application which has been recommended by a Governor or a Statewide Health Coordinating Council for approval. When the Secretary enters into an agreement with an entity under paragraph (1), the Secretary shall notify the Governor of the State in which such entity is located of such agreement.".

(b) The last sentence of section 1515(c)(2) is amended to read as follows: "In considering such applications, the Secretary shall give priority to any application which has been recommended by a Governor or a Statewide Health Coordinating Council for approval.".

(c) Section 1515(c) is amended by adding after paragraph (3) the following:

"(4) Before renewing an agreement with a health systems agency under this subsection, the Secretary shall provide the State health planning and development agency of the State in which the health systems agency is located an opportunity to comment on the performance of such agency and to provide a recommendation on whether such agreement should be renewed and whether its renewal should be made subject to conditions as authorized by paragraph (3).

"(5) If the Secretary enters into an agreement under this subsection with an entity or renews such an agreement, the Secretary shall notify the Governor of the State in which such entity is located of the agreement, its renewal, and, if any conditions have been imposed under paragraph (3), such conditions.".

(d)(1)(A) Paragraphs (1) and (3) of section 1515(c) are each amended by striking out "twelve months" and inserting in lieu thereof "thirty-six months".

(B) The amendments made by subparagraph (A) shall take effect with respect to designation agreements entered into under section 1515(c) of the Public Health Service Act after the date of enactment of this Act.

(2) Section 1515(c)(1) is amended—

(A) by inserting "(A)" after "(c)(1)",

(B) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively,

(C) by amending clause (ii) (as so redesignated) to read as follows:

"(ii) by the Secretary if the Secretary determines, in accordance with subparagraph (B), that the entity is not complying with the provisions of such agreement.", and

(D) by adding at the end the following:

"(B) Before the Secretary may terminate, under subparagraph (A)(ii), an agreement with an entity for designation as the health systems agency for a health service area, the Secretary shall—

"(i) consult with the Governor and the Statewide Health Coordinating Council of each State in which is located the health service area respecting the proposed termination,

"(ii) give the entity notice of the intention to terminate the agreement and in the notice specify with particularity (I) the basis for the determination of the Secretary that the entity is not in compliance with the agreement, and (II) the actions that the entity should take to come into compliance with the agreement, and

"(iii) provide the entity with a reasonable opportunity for a hearing, before an officer or employee of the Department of Health, Education, and Welfare designated for such purpose, on the matter specified in the notice.

The Secretary may not terminate such an agreement before consulting with the National Council on Health Planning and Development respecting the proposed termination. Before the Secretary may permit the term of an agreement to expire without renewing the agreement, the Secretary shall make the consultations prescribed by clause (i) and the preceding sentence, give the entity with which the agreement was made notice of the intention not to renew the agreement and the reasons for not renewing the agreement, and provide, as prescribed by clause (iii), the entity an opportunity for a hearing on the matter specified in the notice.".

(e) Section 1515(c) (as amended by subsection (d)) is amended by adding after clause (ii) of paragraph (1)(A) the following: "A designation agreement under this subsection may be terminated by the Secretary before the expiration of its term if the health service area with respect to which the agreement was entered into is revised under section 1511(b)(4) and the Secretary determines, after consultation with the Governor and Statewide Health Coordinating Council of each State in which the health service area (as revised) is located, that the health systems agency designated under such agreement cannot effectively carry out the agreement for the area (as revised). In

terminating an agreement under the preceding sentence, the Secretary may provide that the termination not take effect before an agreement for the designation of a new agency takes effect and shall provide the agency designated under the agreement to be terminated an opportunity to terminate its affairs in a satisfactory manner.".

(f) Section 1514 is amended (1) by striking out "may" and inserting in lieu thereof "shall", and (2) by striking out "(including entities" through "section 304)".

(g) Section 1515(d) is amended (1) by inserting "agreement" after "If a designation", and (2) by inserting "or is not renewed" after "prescribed for its expiration".

(h) Section 1515(c)(3) is amended (1) by inserting "(A)" after "(3)"; (2) by inserting "during the period of the agreement to be renewed" after "section 1513"; and (3) by adding at the end thereof the following new subparagraph:

"(B) If upon a review under section 1535 of the agency's operation and performance of its functions, the Secretary determines that it has not fulfilled, in a satisfactory manner, the functions of a health systems agency prescribed by section 1513 during the period of the agreement to be renewed or does not continue to meet the requirements of section 1512(b), he may terminate such agreement or return such agency to a conditionally designated status under subsection (b) for a period not to exceed twelve months. At the end of such period, the Secretary shall either terminate the agreement with such agency or enter into an agreement with such agency under paragraph (1). The Secretary may not take the action authorized by the first sentence of this subparagraph unless the Secretary has—

"(i) provided the agency with notice of his intent to return it to a conditional status or terminate the agreement with the agency and included in that notice specification of any functions which the Secretary has determined the agency did not satisfactorily fulfill and of any requirements which the Secretary has determined the agency has not met;

"(ii) provided the agency with a reasonable opportunity for a hearing, before an officer or employee of the Department of Health, Education, and Welfare designated for such purpose, on the action proposed to be taken by the Secretary; and

"(iii) in the case of a proposed termination of an agreement, consulted with the National Council on Health Planning and Development respecting the termination.".

PLANNING GRANTS

SEC. 106. (a) Section 1516 is amended by redesignating subsection (c) as subsection (d) and by striking out subsection (b) and inserting in lieu thereof the following:

"(b) The amount of any grant under subsection (a) to a health systems agency designated under section 1515(b) shall be determined by the Secretary.

"(c)(1) Except as provided in paragraph (2), the amount of a grant under subsection (a) to a health systems agency designated under

section 1515(c) shall be the greater of the amount determined under subparagraph (A), (B), or (C) as follows:

"(A) The amount of a grant to a health systems agency shall be the lesser of—

"(i) the product of $0.60 and the population of the health service area for which the agency is designated, or

"(ii) $3,750,000.

"(B) (i) If the application of the health systems agency for such grant states that the agency, in its latest fiscal year ending before the period in which such grant will be available for obligation, collected non-Federal funds meeting the requirements of clause (ii) for the purposes for which such grant may be made, the amount of such grant shall be the sum of—

"(I) the amount determined under subparagraph (A) or (C), whichever is applicable, and

"(II) the lesser of the amount of such non-Federal funds or $200,000 or the product of $0.25 and the population of the health service area for which the agency is designated, whichever is greater.

"(ii) The non-Federal funds which an agency may use for the purpose of obtaining a grant under subsection (a) which is computed on the basis of the formula prescribed by clause (i) shall be funds which are not paid to the agency for the performance of particular services by it and which are otherwise contributed to the agency without conditions as to their use other than the condition that the funds shall be used for the purposes for which a grant made under this section may be used.

"(C) The amount of a grant to a health systems agency may not be less than—

"(i) in the case of a grant made in the fiscal year ending September 30, 1979, $175,000 and, to the extent appropriations are specifically made after October 1, 1979, to provide the additional amount authorized by this clause, an amount which bears the same ratio to $50,000 as the number of days beginning in the period beginning on October 1, 1979, and ending on the date of the period for which the grant was made bears to 365,

"(ii) $225,000 in the case of a grant made in the fiscal year ending September 30, 1980,

"(iii) $245,000 in the case of a grant made in the fiscal year ending September 30, 1981, and

"(iv) $260,000 in the case of a grant made in any succeeding fiscal year.

"(2) If the Secretary determines, after review of the budget of a health systems agency and after consultation with the State health planning and development agency of the State in which such agency is located, that the amount of a grant which is to be made to the agency in accordance with paragraph (1) is in excess of the amount needed by the agency to adequately perform its functions under its designation agreement, the amount of the grant to the agency shall be such amount as the Secretary determines the agency needs for the performance of such functions.".

(b) Subsection (d) (as so redesignated) is amended by striking out paragraph (2) and inserting in lieu thereof the following:

"(2) Of the amount appropriated under paragraph (1) for any fiscal year, the Secretary may use not more than 5 per centum of such amount to increase the amount of grants in such fiscal year to health systems agencies under subsection (a) to assist the agencies in meeting extraordinary expenses (including ertraordinary expenses resulting from an agency's health service area being located in more than one State or from an agency serving a large rural or urban medically underserved population or a geographically large health service area) which would not be covered under the amount of a grant that would be available to an agency under subsection (c) and in improving their performance as a result of the development and implementtion of innovative health planning techniques.".

"(3) Notwithstanding subsection (c)(1), if the total of the amounts appropriated under paragraph (1) for any fiscal year (reduced by the amount to be retained by the Secretary for use under paragraph (2)) is less than the amount required to make grants to each health system agency designated under section 1515(c) in the amount prescribed for such agency by subparagraph (A), (B), or (C) of subsection (c)(1), the Secretary shall make a pro rata reduction in the amount of the grant to each such agency, but, to the extent of available appropriations, no such agency shall receive a grant in an amount less than the amount prescribed by such subparagraph (C) for such fiscal year.".

(c) The second sentence of section 1516(a) is amended by inserting "(including submission of the health systems agency's budget)" after "such conditions".

CARRYOVER OF GRANT FUNDS

SEC. 107. (a) Section 1513(c)(3) is amended by striking out the period at the end of the fourth sentence and inserting in lieu thereof the following: "unless another grant or contract is made or entered into, in which case the funds under the first grant or contract shall remain available for the period of the second grant or contract. Funds from a first grant or contract which remain available for obligation in the period of a second grant or contract shall not be considered in determining the amount of the second grant or contract.".

(b)(1) The second sentence of section 1516(a) is amended by striking out ", and shall be available for obligation" and all that follows in such sentence and inserting in lieu thereof a period.

(2) Such section is amended by inserting after the second sentence the following: "Funds under a grant which remain available for obligation at the end of the fiscal year in which the grant has been made shall remain available for obligation in the succeeding fiscal year, except that (1) no funds under any grant to an agency may be obligated in any period in which a designation agreement is not in effect for such agency, and (2) notwithstanding clause (1), a grant made to a conditionally designated entity with which the Secretary will not enter into a designation agreement under section 1515(c) shall be available for obligation for such additional period as the

Secretary determines such entity will require to satisfactorily terminate its activities under the agreement for its conditional designation.".

(c) The second sentence of section 1525(a) is amended to read as follows: "Funds under a grant which remain available for obligation at the end of the fiscal year in which the grant has been made shall remain available for obligation in the succeeding fiscal year, but no funds under any grant to a State Agency may be obligated in any period in which a designation agreement is not in effect for such State Agency.".

(d) Section 1526(c) is amended (1) by striking out "(1) such a grant" and all that follows through "(2)", and (2) by inserting at the end the following: "Funds under a grant which remain available for obligation at the end of the fiscal year in which the grant has been made shall remain available for obligation in the succeeding fiscal year, but no funds under any grant to a State Agency may be obligated in any period in which a designation agreement is not in effect for such State Agency.".

MEMBERSHIP REQUIREMENTS

SEC. 108. (a) (1) Clause (i) of section 1512(b) (3) (C) is amended (A) by inserting "(I)" after "shall be", and (B) by striking out all after "providers of health care" and inserting in lieu thereof ", and (II) broadly representative of the health service area and shall include individuals representing the principal social, economic, linguistic, handicapped, and racial populations and geographic areas of the health service area and major purchasers of health care (including labor organizations) in the area.".

(2) The first sentence of section 1512(b) (3) (C) (ii) is amended (A) by striking out "residents of" and inserting in lieu thereof "residents of, or have their principal place of business in,", (B) in subclause (I), by inserting "podiatrists, physician assistants," after "optometrists,", (C) by inserting "rehabilitation facilities," after "long-term care facilities," in subclause (II), (D) by striking out "substance abuse" in subclause (II) and inserting in lieu thereof "alcohol and drug abuse", (E) by striking out "and" at the end of subclause (IV), and (F) by inserting before the period a comma and the following: "and (VI) other providers of health care".

(3) The second sentence of section 1512(b) (3) (C) (ii) is amended (A) by striking out "one-third" and inserting in lieu thereof "one-half", and (B) by inserting before the period at the end the following: "and of such direct providers of health care, at least one shall be a person engaged in the administration of a hospital".

(b) (1) Section 1512(b) (3) (C) (iii) (I) is amended by striking out "and other representatives of governmental authorities" and inserting in lieu thereof "and other representatives of units of general purpose local government".

(2) Subclause (II) of such section is amended (A) by striking out "is equal" and inserting in lieu thereof "is at least equal", and (B) by striking out "and" at the end.

(3) Such section is amended by striking out subclause (III) and inserting in lieu thereof the following:

"(III) include (through consumer and provider members) individuals who are knowledgeable about mental health services,

"(IV) if the health systems agency serves an area in which there is located one or more hospitals or other health care facilities of the Veterans' Administration, include, as a nonvoting, ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration shall have designated for such purpose, and

"(V) if the agency serves an area in which there is located one or more health maintenance organizations, include at least one member who is representative of such organizations.".

(c) Section 1512(b)(3)(C) is amended by inserting after and below clause (iv) the following:

"For purposes of clause (iii)(I), to be considered a representative of a unit of general purpose local government, an individual must be appointed by such unit or a combination thereof, and the State government of a State which is comprised of a single health service area shall be deemed to be a unit of general purpose local government. A member of a governing body appointed pursuant to clause (iii)(IV) shall not be considered in determining the number of members of the governing body for purposes of the numerical limit prescribed by subparagraph (A).".

(d)(1) Section 1512(b)(3)(C)(i) is amended (A) by striking out "(nor within the twelve months preceding appointment been)", and (B) by inserting "(including labor organizations and business corporations)" after "major purchasers of health care".

(2) Section 1531(3) is amended to read as follows:

"(3) The term 'provider of health care' means an individual—

"(A) who is a direct provider of health care (including a physician, dentist, nurse, podiatrist, optometrist, physician assistant, or ancillary personnel employed under the supervision of a physician) in that the individual's primary current activity is the provision of health care to individuals or the administration of facilities or institutions (including hospitals, long-term care facilities, rehabilitation facilities, alcohol and drug abuse treatment facilities, outpatient facilities, and health maintenance organizations) in which such care is provided and, when required by State law, the individual has received professional training in the provision of such care or in such administration and is licensed or certified for such provision or administration;

"(B) who holds a fiduciary position with, or has a fiduciary interest in, any entity described in clause (ii) or (iv) of subparagraph (C) other than an entity described in such clause which is also an entity described in section 501(c)(3) of the Internal Revenue Code of 1954 and which does not have as its primary purpose the delivery of health care, the conduct of research, the conduct of instruction for health professionals, or the production of drugs or articles described in clause (iii) of subparagraph (C);

"(C) who receives (either directly or through the individual's spouse) more than one-fifth of his gross annual income from any one or combination of—

"(i) fees or other compensation for research into or instruction in the provision of health care,

"(ii) entities engaged in the provision of health care or in research or instruction in the provision of health care,

"(iii) producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care, or

"(iv) entities engaged in producing drugs or such other articles;

"(D) who is the member of the immediate family of an individual described in subparagraph (A), (B), or (C); or

"(E) who is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits.

An individual shall not be considered a provider of health care solely because the individual is the member of the governing board of an entity described in clause (ii) or (iv) of subparagraph (C).".

(e) Section 1512(b)(3)(C)(iv) is amended (1) by striking out "of its members", and (2) by adding before the period at the end a comma and the following "except that appointments shall be made to such subcommittees and groups in such a manner that a majority of their members shall be consumers of health care".

GOVERNING BODY SELECTION

SEC. 109. Section 1512(b)(3) is amended by adding after subparagraph (C) the following new subparagraph:

"(D) SELECTION.—Each health systems agency shall establish a process for the selection of the members of its governing body which process is designed to assure that (i) such members are selected in accordance with the requirements of subparagraph (C), (ii) there is the opportunity for broad participation in such process by the residents of the health service area of the agency, and (iii) the participation of such residents will be encouraged and facilitated. Such process shall prohibit the selection of more than one-half of the members of such body by members of such body. Each agency shall make public such process and report it to the Secretary. The requirements of this subparagraph shall apply with respect to the selection of members of a subarea advisory council if the council is authorized to select or selects one or more members of the governing body of a health systems agency.".

RESPONSIBILITIES OF GOVERNING BODIES

SEC. 110. (a) Section 1512(b)(3)(B)(i) is amended to read as follows:

"(i) shall be responsible for—

"(I) the internal affairs of the health systems agency, including matters relating to the staff of the agency and the agency's budget, except that the governing body for health planning of an agency which is a public regional planning body or unit of general local government shall not be responsible for the establishment of personnel rules and practices for the staff of the agency or for the agency's budget unless authorized by the planning body or unit of government, and

"(II) procedures and criteria developed and published pursuant to section 1532 and applicable to its functions under subsections (e), (f), and (g) of section 1513;".

(b) Section 1512(b)(3)(A) is amended (1) by striking out "have a governing body for health planning, which is established in accordance with subparagraph (C)," and inserting in lieu thereof "appoint a governing body for health planning in accordance with subparagraph (C)", (2) by striking out "which has exclusive" and inserting in lieu thereof "which shall have exclusive", and (3) by striking out "not more than twenty-five members" and inserting in lieu thereof "not less than ten members and not more than thirty members".

(c) Section 1512(b)(3)(B)(iv) is amended by striking out "(g), and (h)" and inserting in lieu thereof "and (g)".

(d)(1) Paragraph (4) of section 1512(b) is amended to read as follows:

"(4) LIABILITY.—

"(A) IN GENERAL.—Except as provided in subparagraph (B)—

"(i) a health systems agency shall not, by reason of the performance of any duty, function, or activity, required of, or authorized to be undertaken by, the agency, be liable for the payment of damages under any law of the United States or any State (or political subdivision thereof) if the member of the governing body of the agency or employee of the agency who acted on behalf of the agency in the performance of such duty, function, or activity acted within the scope of his duty, function, or activity as such a member or employee, exercised due care, and acted without malice toward any person affected by it; and

"(ii) no individual member of the governing body of a health systems agency or employee of a health systems agency shall, by reason of his performance on behalf of the agency of any duty, function, or activity required of, or authorized to be undertaken by, the agency, be liable for the payment of damages under any law of the United States or any State (or political subdivision of a State) if he believed he was acting within the scope of his duty, function, or activity as such a member or employee, and, with respect to such performance, acted without gross negligence or malice toward any person affected by it.

"(B) EXCEPTION.—Subparagraph (A) does not apply with respect to civil actions for bodily injury to individuals or physical damages to property brought against a health systems agency or any member of the governing body of or employee of such an agency.".

(2) Section 1524 is amended by adding at the end thereof the following new subsection:

"(d) No individual who as a member or employee of a SHCC shall, by reason of his performance of any duty, function, or activity required of, or authorized to be undertaken by, the SHCC, be liable for payment of damages under any law of the United States or any State (or political subdivision of a State) if he believed he was acting within the scope of his duty, function, or activity as such a member or employee, and acted, with respect to that performance, without gross negligence or malice toward any person affected by it.".

(e)(1) The first sentence of section 1512(b)(3)(A) is amended by striking out "to perform for the agency" and inserting in lieu thereof "to perform".

(2)(A) Section 1512(b)(3)(B)(ii) is amended by inserting before the semicolon the following: "and in the case of a health systems agency which is a public regional planning body or unit of general local government, the planning body or unit of government shall be given, in accordance with sections 1513(b)(2) and 1513(b)(3) a reasonable opportunity to comment on the health systems plan and annual implementation plan proposed by the governing body and to propose additions to and other revisions in it".

(B) The amendment made by subparagraph (A) shall not apply with respect to a health systems agency for which a designation under section 1515 of the Public Health Service Act was in effect on January 1, 1979, and which is a unit of general local government.

(3) Clauses (iii) and (iv) of section 1512(b)(3)(B) are each amended by striking out "approval" and inserting in lieu thereof "approval or disapproval".

(4) Section 1513(b)(2) is amended by adding at the end the following: "If the health systems agency is a public regional planning body or unit of general local government, the planning body or unit of government shall be given a reasonable opportunity to comment on the proposed HSP and to propose additions to any other revisions in it. Any such proposed additions or other revisions not included in the HSP established by the agency shall be appended to the HSP. If the goals contained in the HSP are not consistent with guidelines issued by the Secretary under section 1501, it shall provide the State health planning and development agency and the Secretary with a detailed statement of the reasons for the inconsistency between such goals and guidelines. When making such HSP available to a Statewide Health Coordinating Council under section 1524(c)(2)(A), the agency shall also report such statement to such Council.".

(f) Section 1513(a) is amended by adding after the first sentence the following: "None of the funds authorized to be appropriated under this title may be used by a health systems agency directly to pay any individual to influence the issuance, amendment, or revocation of any Executive order or regulation by any Federal, State, or local chief executive officer or agency or to influence the passage, amendment or defeat of any legislation by the Congress or by any State or local legislative body. The preceding sentence does not apply with respect to compensation paid by a health systems agency to an employee of the agency unless the primary responsibility of the employee for the agency is to influence such governmental action.".

MEETINGS AND RECORDS

SEC. 111. (a) Section 1512(b)(3)(B)(viii) is amended by striking out "conduct its business meetings in public" and inserting in lieu thereof "hold in public meetings to conduct the business of the agency (other than any part of a meetng in which it is likely, as determined by the governing body, that information respecting the performance or remuneration of an employee of the agency will be disclosed and such a disclosure would constitute a clearly unwarranted invasion of per-

sonal privacy of the employee or that information relating to the agency's participation in a judicial proceeding will be disclosed)", and (2) by striking out "its records and data" and inserting in lieu thereof "records and data of the agency (other than records or data respecting the performance or remuneration of an employee the disclosure of which would constitute a clearly unwarranted invasion of the personal privacy of the employee and records or data of the agency relating to its participation in a judicial proceeding)".

(b) (1) Section 1512(b)(6)(A) is amended by inserting after "such information" the following: "(other than information respecting the performance or remuneration of an employee of the agency the disclosure of which would constitute a clearly unwarranted invasion of the personal privacy of the employee or information relating the agency's participation in a judicial proceeding)".

(2) Section 1512(b)(6) is amended by redesignating subparagraphs (A), (B), and (C) as subparagraphs (B), (C), and (D) and by adding before subparagraph (B) (as so redesignated) the following:

"(A) provide that any executive committee of the agency and any entity appointed by the governing body or executive committee of the agency shall (i) hold in public meetings to conduct the business of the committee or entity (other than any part of a meeting in which it is likely, as determined by the executive committee or entity, that information respecting the performance or remuneration of an employee of the agency will be disclosed and such disclosure would constitute a clearly unwarranted invasion of personal privacy of the employee or that information relating the agency's participation in a judicial proceeding will be disclosed), and (ii) give adequate notice of its meetings to those persons who have requested such notice;".

(c) Section 1522(b)(6) is amended (1) by striking out "conduct its business meetings in public" and inserting in lieu thereof "hold in public meetings to conduct the business of the State Agency (other than any part of a meeting in which it is likely, as determined by the State Agency, that information respecting the performance or remuneration of an employee of the agency will be disclosed and such a disclosure would constitute a clearly unwarranted invasion of personal privacy of the employee or that information relating to the agency's participation in a judicial proceeding will be disclosed)", and (2) by striking out "its records and data" and inserting in lieu thereof "records and data of the agency (other than records or data respecting the performance or remuneration of an employee the disclosure of which would constitute a clearly unwarranted invasion of the personal privacy of the employee and records or data of the agency relating to its participation in a judicial proceeding)".

SUPPORT AND REIMBURSEMENT FOR MEMBERS OF GOVERNING BODIES

SEC. 112. (a) Section 1512(b)(3) is amended by adding after subparagraph (D) (added by section 109 of this Act) the following new subparagraph:

"(E) SUPPORT.—Each health systems agency shall have an identifiable program of providing assistance to the members of

its governing body, executive committee (if any), and any entity appointed by the governing body or executive committee in making decisions for the agency, and shall include in such program means to determine the support needs of the members and to provide for meeting those needs (including the provision of training and continuing education).".

(b) Section 1512(b)(3)(B)(vi) is amended (1) by striking out "reimburse" and inserting in lieu thereof "reimburse (or when appropriate make advances to)", and (2) by inserting "and performing any other duties and functions of the health systems agency" after "governing body".

(c) Section 1512(b)(2)(A) is amended by adding at the end the following: "At least one member of the staff shall be designated to have the responsibility of providing the members of the governing body of an agency (particularly the consumer members) with such information and technical assistance as they may require to effectively perform their functions.".

CONFLICTS OF INTEREST

SEC. 113. (a) Section 1512(b)(3) is amended by adding after subparagraph (E) (added by section 112 of this Act) the following new subparagraph:

"(F) CONFLICTS OF INTEREST.—No member of a governing body, executive committee, or any entity appointed by a governing body, or executive committee may, in the exercise of any function of the agency described in subsection (e), (f), or (g) of section 1513, vote on any matter before the governing body, executive committee, or any such entity respecting any individual or entity with which such member has (or, within the twelve months preceding the vote, had) any substantial ownership, employment, medical staff, fiduciary, contractual, creditor, or consultative relationship. A governing body, executive committee, and any entity appointed by a governing body or executive committee shall require each of its members who has or has had such a relationship with an individual or entity involved in any matter before the governing body, committee, or entity to make a written disclosure of such relationship before any action is taken by the body, committee, or entity with respect to such matter in the exercise of any function of the agency described in section 1513 and to make such relationship public in any meeting in which such action is to be taken.".

(b) Section 1524 is amended by adding at the end the following new subsection:

"(d) No member of any SHCC may, in the exercise of any function of the SHCC described in subsection (c)(6), vote on any matter before the SHCC respecting any individual or entity with which such member has (or, within the twelve months preceding the vote, had) any substantial ownership, employment, medical staff, fiduciary, contractual, creditor, or consultative relationship. Each SHCC shall require each of its members who has or has had such a relationship with an individual or entity involved in any matter before the SHCC to make a written disclosure of such relationship before any action

is taken by the SHCC with respect to such matter in the exercise of any function under subsection (c) and to make such relationship public in any meeting in which such action is to be taken.".

STAFF EXPERTISE

SEC. 114. Section 1512(b)(2)(A) is amended (1) by striking out "health resources" in the first sentence and inserting in lieu thereof "health (including mental health) resources", (2) by striking out "and" after "health planning," in such sentence, (3) by inserting before the period in such sentence a comma and the following: "(v) financial and economic analysis, and (vi) prevention of disease and other public health matters", and (4) by striking out "health resources" in the second sentence and inserting in lieu thereof "health (including mental health) resources".

HEALTH PLAN REQUIREMENTS

SEC. 115. (a) Section 1524(c)(1) is amended by striking out "Review" and inserting in lieu thereof "Establish (in consultation with the health systems agencies in the State and the State Agency) a uniform format for HSP's and review".

(b)(1) Section 1513(b)(2)(A) is amended by inserting "(primarily with regard to health care equipment and to health services provided by health care institutions, health care facilities, and other providers of health care and to other health resources)" after "healthful environment".

(2) Section 1513(b)(2) is amended (A) by striking out "establish" in the first sentence and inserting in lieu thereof "establish (in accordance with the format established pursuant to section 1524(c)(1))" and (B) by inserting after the first sentence the following: "The HSP of the agency shall include goals for the delivery of mental health services in its health service area which goals shall be developed under a procedure under which persons (acting as an advisory group or subcommittee appointed by the agency or, if the agency requests and is authorized by the Secretary to use an existing group, acting as part of such a group) knowledgeable about such services (including services for alcohol and drug abuse) will be consulted with respect to such goals.".

(3) Section 1522(b)(7) is amended (A) by striking out "and" at the end of clause (A), and (B) by inserting before the period the following: ", and (C) provide for consultation and coordination (in accordance with regulations of the Secretary) between the State Agency, the Statewide Health Coordinating Council, the State mental health authority, and other agencies of the State government designated by the Governor".

(c)(1)(A) Section 1523(a)(1) is amended by inserting "(A)" after "(1)" and by inserting before the period a comma and the following: "and (B) determine the statewide health needs of the State after providing reasonable opportunity for the submission of written recommendations respecting such needs by the State health authority, the State mental health authority, and other agencies of the State government, designated by the Governor for the purpose of making such rec-

ommendations, and after consulting with the Statewide Health Coordinating Council".

(B) Section 1523(a)(2) is amended (i) by striking out "statewide health needs" and inserting in lieu thereof "statewide health needs determined under paragraph (1)(B)", and (ii) by inserting after the first sentence the following: "In carrying out its functions under this paragraph, the State Agency shall refer the HSP's to the State health authority, the State mental health authority, and other agencies of the State government (designated by the Governor to make the review prescribed by this sentence) to review the goals and related resource requirements of the HSP's and to make written recommendations to the State Agency respecting such goals and requirements.".

(C) Subsection (a) of section 1523 is amended by adding after and below the last paragraph the following: "If in determining the statewide health needs under paragraph (1)(B) or in preparing or revising a preliminary State health plan under paragraph (2) the State Agency does not take an action proposed in a recommendation submitted under the applicable paragraph, the State Agency shall when publishing such needs or health plan make available to the public a written statement of its reasons for not taking such action.".

(D) Section 1524(c)(2) is amended (i) by inserting "as determined by the State Agency of the State" after "statewide health needs" each place it occurs, and (ii) by inserting at the end of subparagraph (B) the following: "If in preparing or revising the State health plan the SHCC does not take an action proposed in a recommendation submitted under section 1523(a)(1)(B), the SHCC shall when publishing such plan make available to the public a written statement of its reasons for not taking such action.".

(2) Section 1513(b)(2) is amended (A) by striking out "and" after "resources of the area;", (B) by striking out "resources" and inserting in lieu thereof "resources (including entities described in section 1532(c)(7))", and (C) by inserting before the period at the end of the first sentence a semicolon and the following: "(D) which are responsive to statewide health needs as determined by the State health planning and development agency".

(d)(1) The first sentence of section 1513(b)(2) (as amended by subsection (c)(2)) is further amended by inserting before the period at the end a semicolon and the following: "(E) which describe the institutional health services (as defined in section 1531(5)) needed to provide for the well-being of persons receiving care within the health service area, including, at a minimum, acute inpatent (including psychiatric inpatient, obstetrical inpatient, and neonatal inpatient), rehabilitation, and long-term care services; and (F) which describe other health services needed to provide for the well-being of persons receiving care within the health service area, including, at a minimum, preventive, ambulatory, and home health services and treatment for alcohol and drug abuse".

(2) Section 1513(b)(2) is amended by adding after the sentence added by subsection (b)(2) the following: "The HSP shall describe the number and type of resources, including facilities, personnel, major medical equipment, and other resources required to meet the goals of the HSP and shall state the extent to which existing health care facilities are in need of modernization, conversion to other uses, or closure

and the extent to which new health care facilities need to be constructed or acquired.".

(3) Section 1524(c)(2(A) is amended by adding after the second sentence the following new sentences: "The plan shall also describe the institutional health services (as defined in section 1531(5)) needed to provide for the well-being of persons receiving care within the State, including, at a minimum, acute inpatient (including psychiatric inpatient, obstetrical inpatient, and neonatal inpatient), rehablitation, and long-term care services; and also describe other health services needed to provide for the well-being of persons receiving care within the State, including, at a minimum, prevented, ambulatory, and home health services and treatment for alcohol and drug abuse. The plan shall also describe the number and type of resources, including facilities, personnel, major medical equipment, and other resources required to meet the goals of the plan and shall state the extent to which existing health care facilities are in need of modernization, conversion to other uses, or closure and the extent to which new health care facilities need to be constructed or acquired."

(e) Section 1513(b)(3) is amended (1) by inserting after "goals of the HSP" in the first sentence the following: "as stated in the HSP of the agency or, if revised under section 1524(c)(2)(A) when included in the State health plan, as so revised)", and (2) by adding at the end the following: "The AIP shall include a statement of the personnel, facilities, and other resources which the agency determines are required to meet the objectives described pursuant to the first sentence. The AIP shall be established, annually reviwed, and amended in accordance with the procedures set forth in the last two sentences of paragraph (2). If the health systems agency is a public regional planning body or unit of general local government, the planning body or unit of government shall be given a reasonable opportunity to comment on the proposed AIP and to propose additions to and other revisions in it. Any such proposed additions or other revisions not included in AIP approved by the agency shall be appended to the AIP.".

(f) Section 1513(b)(2)(C) is amended by striking out "and is consistent with".

(g) Section 1524(c)(2) is amended by adding at the end the following:

> *"(C) The State health plan or any revised State health plan approved by the SHCC shall be the State health plan for the State for purposes of this title after it is approved by the Governor of the State. The State health plan for a State may be disapproved by the Governor of the State only if the Governor determines that the plan does not effectively meet the statewide health needs of the State as determined by the State Agency for the State. In disapproving a State health plan, a Governor shall make public a detailed statement of the basis for the determination that the plan does not meet such needs and shall specify the changes in the plan which the Governor determines are needed to meet such needs. Subparagraph (B) does not apply to the preparation of revisions of a State health plan disapproved by a Governor.*
>
> *"(D) In carrying out its functions with respect to the goals and resource requirements for mental health services of the State health plan, the SHCC may establish a procedure under which per-*

sons (acting as or as part of an advisory group or subcommittee appointed by the SHCC) knowledgeable about mental health services (including services for alcohol and drug abuse) will have the opportunity to make recommendations to the SHCC respecting such services.

"(E) The State health authority, the State mental health authority, and other agencies of the State government, designated by the Governor, shall carry out those parts of the State health plan which relate to the government of the State.

"(F) If a State health plan as required by this subsection is not in effect for a State, the Secretary may not make any grant under section 1525 to the State Agency for such State.".

(h) Section 1513(c)(2) is amended (1) by striking out "may" and inserting in lieu thereof "shall", and (2) by inserting "in obtaining and filling out the necessary forms and may provide other technical assistance" after "technical assistance".

(i)(1)(A) The first sentence of section 1513(b)(2) is amended by striking out "annually" and inserting in lieu thereof "triennially".

(B) The second sentence of section 1513(b)(2) is amended by striking out "Before establishing an HSP" and inserting in lieu thereof "Before establishing or amending an HSP and in its review of an HSP".

(2) The first sentence of section 1523(a)(2) and the first sentence of section 1524(c)(2)(A) are each amended by striking out "and review and revise as necessary (but at least annually)" and inserting in lieu thereof ", review at least triennially, and revise as necessary".

(3) Section 1524(c)(1) (as amended by subsection (a)) is amended by striking out "review annually and coordinate the HSP and AIP" and inserting in lieu thereof "review and coordinate at least triennially the HSP and review at least annually the AIP".

(4) The third sentence of section 1524(c)(2)(A) is amended by striking out "for each year".

(j)(1) Section 303(a) of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 is amended by adding after and below paragraph (16) the following: "Such plan shall be consistent with the State health plan in effect for such State under section 1524(c) of the Public Health Service Act.".

(2) Section 409(e) of the Drug Abuse Office and Treatment Act of 1972 is amended by adding after and below paragraph (13) the following: "Such plan shall be consistent with the State health plan in effect for such State under section 1524(c) of the Public Health Service Act.".

(k)(1) Section 237(a) of the Community Mental Health Centers Act is amended in the matter preceding paragraph (1) by inserting "shall be consistent with the State health plan in effect for such State under section 1524(c) of the Public Health Service Act and" before "shall be".

(2) Paragraph (2)(D)(iv) of subsection (d) of section 314 of the Public Health Service Act (as so redesignated by section 128(b)) is amended by striking out "a plan" and inserting in lieu thereof "a plan which is consistent with the State health plan in effect for the State under section 1524(c) and".

CRITERIA AND PROCEDURES FOR REVIEWS

SEC. 116. (a) (1) The first sentence of section 1532(a) is amended (A) by striking out "; and in performing" and inserting in lieu thereof "; in performing", and (B) by inserting before the period a semicolon and the following: "and in performing its review functions a Statewide Health Coordinating Council shall (except to the extent approved by the Secretary) follow procedures and apply criteria developed and published by the Council in accordance with regulations of the Secretary".

(2) The second sentence of such section is amended by striking out "and States Agencies" and inserting in lieu thereof ", State Agencies, and Statewide Health Coordinating Councils".

(b) (1) Subsections (b) and (c) of section 1532 are each amended—

(A) by striking out "agency and State Agency" each place it occurs (other than in paragraph (11) of subsection (b)) and inserting in lieu thereof "agency, State Agency, and Statewide Health Coordinating Council", and

(B) by striking out "agency or State Agency" each place it occurs and inserting in lieu thereof "agency, State Agency, or Statewide Health Coordinating Council".

(2) Subsection (b) (4) of such section is amended by striking out "agency or a State Agency" and inserting in lieu thereof "agency, State Agency, or Statewide Health Coordinating Council".

(3) Section 1532(c) (1) is amended by striking out "HSP and AIP" and inserting in lieu thereof "HSP, AIP, and State health plan".

(c) Section 1532(a) is amended by adding at the end the following: "Health systems agencies, the State Agency, and, if appropriate, the Statewide Health Coordinating Council within each State shall cooperate in the development of procedures and criteria under this subsection to the extent appropriate to the achievement of efficiency in their reviews and consistency in criteria for such reviews.".

(d) (1) (A) Section 1532(b) (1) is amended (i) by striking out "Written" and inserting in lieu thereof "Timely written", and (ii) by inserting before the period "and, if a person has asked the entity conducting the review to place the person's name on a mailing list maintained by the entity, such notification shall be sent to such person".

(B) Section 1532(b) (7) is amended by striking out "Notification" and inserting in lieu thereof "Timely notification".

(2) Section 1532(b) (2) is amended by adding at the end the following: "If, after a review has begun, a State Agency, health systems agency, or Statewide Health Coordinating Council requires, in accordance with paragraph (3), the person subject to the review to submit information respecting the subject of the review, such person shall be provided at least fifteen days to submit the information."

(3) Section 1532(b) is amended by adding after paragraph (11) the following new paragraph:

"(12) The following procedural requirements with respect to proceedings under a certificate of need program:

"(A) Hearings under a certificate of need program shall be held before a State Agency or a health systems agency to which the State Agency has delegated the authority to hold such a hearing.

In a hearing under the program, any person shall have the right to be represented by counsel and to present oral or written arguments and evidence relevant to the matter which is the subject of the hearing, any person directly affected by the matter which is the subject of the hearing may conduct reasonable questioning of persons who make factual allegations relevant to such matter, and a record of the hearing shall be maintained. The requirements of this subparagraph do not apply to hearings held by a health systems agency in the performance of a review under section 1513(f).

"(B) Any decision of a State Agency to issue or to not issue a certificate of need or to withdraw a certificate of need shall be based solely (i) on the review of the State Agency conducted in accordance with procedures and criteria it has adopted in accordance with this section and regulations promulgated under this section, and (ii) on the record established in administrative proceedings held with respect to the application for such certificate or the Agency's proposal to withdraw the certificate, as the case may be. Any decision of a State Agency to approve or disapprove an application for an exemption under section 1527(b) shall be based solely on the record established in the administrative proceedings held with respect to the application.

"(C)(i) The State Agency shall establish the period within which approval or disapproval by the State Agency of applications for certificates of need and for exemptions under section 1527(b) shall be made. If, after a review has begun by the State Agency, the State Agency or health systems agency requires, in accordance with section 1532(b)(3), an applicant to submit information respecting the subject of the review, the period prescribed pursuant to the preceding sentence shall, at the request of the applicant, be extended fifteen days.

"(ii) If the State Agency fails to approve or disapprove an application within the applicable period under clause (i), the applicant may, within a reasonable period of time following the expiration of such period, bring an action in an appropriate State court to require the State Agency to approve or disapprove the application.

"(D) The program shall provide that each decision of the State Agency to issue, not to issue, or to withdraw a certificate of need or to approve or disapprove an application for an exemption under section 1527(b) shall, upon request of any person directly affected by such decision, be administratively reviewed under an appeals mechanism consistent with State law governing the practices and procedures of administrative agencies or, if there is no such State law, by an entity (other than the State Agency) designated by the Governor.

"(E) Any person adversely affected by a final decision of a State Agency with respect to a certificate of need or an application for an exemption under section 1527(b) and a health systems agency if the decision respecting the certificate of need is inconsistent with a recommendation made by the agency to the State Agency with respect to the certificate of need may, within a reasonable period of time after such decision is made (and any administrative review of it completed), obtain judicial review of

it in an appropriate State court. The decision of the State Agency shall be affirmed upon such judicial review unless it is found to be arbitrary or capricious or not made in compliance with applicable law.

"*(F) There shall be no ex parte contacts—*

"*(i) in the case of an application for a certificate of need, between the applicant for the certificate of need, any person acting on behalf of the applicant, or any person opposed to the issuance of a certificate for the applicant and any person in the State Agency who exercises any responsibility respecting the application after the commencement of a hearing on the applicant's application and before a decision is made with respect for it; and*

"*(ii) in the case of a proposed withdrawal of a certificate of need, between the holder of the certificate of need, any person acting on behalf of the holder, or any person in favor of the withdrawal and any person in the State Agency who exercises responsibility respecting withdrawal of the certificate after commencement of a hearing on the Agency's proposal to withdraw the certificate of need and before a decision is made on withdrawal.*

The requirements of this paragraph are in addition to the requirements of the other paragraphs of this subsection and may, as appropriate, apply to other review programs.".

(e) Section 1532(b) is amended by adding after paragraph (12) (added by subsection (d)) the following new paragraph:

"*(13)(A) In the case of reviews by health systems agencies under section 1513(f) and by State Agencies under paragraphs (4) and (5) of section 1523(a)—*

"*(i) provision for applications to be submitted in accordance with a timetable established by the reviewing agency,*

"*(ii) provision for such reviews to be undertaken in a timely fashion, and*

"*(iii) provision for all completed applications pertaining to similar types of services, facilities, or equipment affecting the same health service area to be considered in relation to each other (but no less often than twice a year).*

"*(B) In the case of reviews by health systems agencies under section 1513(g) and by State Agencies under paragraph (6) of section 1523(a), provision for reviews of similar types of institutional health services affecting the same health service area to be considered in relation to each other.*"

(f) Section 1532(c)(6) is amended to read as follows:

"*(6) In the case of health services proposed to be provided—*

"*(A) the availability of resources (including health manpower, management personnel, and funds for capital and operating needs) for the provision of such services,*

"*(B) the effect of the means proposed for the delivery of such services on the clinical needs of health professional training programs in the area in which such services are to be provided,*

"*(C) if such services are to be available in a limited number of facilities, the extent to which the health professions schools*

in the area will have access to the services for training purposes,

"*(D) the availability of alternative uses of such resources for the provision of other health services, and*

"*(E) the extent to which such proposed services will be accessible to all the residents of the area to be served by such services.*".

(g) (1) Section 1532(c) (9) (B) is amended by inserting "and on the costs and charges to the public of providing health services by other persons" after "construction project".

(2) Section 1532(c) (as amended by section 103(c)) is amended by adding at the end the following:

"*(13) In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities similar to those proposed.*".

"*(14) In the case of existing services or facilities, the quality of care provided by such services or facilities in the past.*".

(h) Section 1532(a) is amended by adding after the sentence added by subsection (c) the following: "The Secretary shall review at least annually regulations promulgated under this section and provide opportunity for the submission of comments by health systems agencies, State Agencies, and Statewide Health Coordinating Councils on the need for the revision of such regulations. At least forty-five days before the initial publication of a regulation proposing a revision in a regulation of the Secretary under this section, the Secretary shall, with respect to such proposed revision, consult with and solicit the recommendations from health systems agencies, State Agencies, and Statewide Health Coordinating Councils."

(i) (1) Section 1532(b) (3) is amended by adding at the end the following: "Each health systems agency, State Agency, and Statewide Health Coordinating Council shall develop procedures to assure that requests for information in connection with a review under this title are limited to only that information which is necessary for the agency, State Agency, or Statewide Health Coordinating Council to perform the review.".

(2) Section 1532(b) (10) is amended by striking out "pertinent" and inserting in lieu thereof "essential".

CERTIFICATE OF NEED PROGRAMS

SEC. 117. (a) Part C of title XV is amended by adding at the end the following:

"*CERTIFICATE OF NEED PROGRAM*

"*SEC. 1527. (a) The certificate of need program required by section 1523(a) (4) (B) shall, in accordance with this section, provide for the following:*

"*(1) Review and determination of need under such program for—*

"*(A) major medical equipment and institutional health services, and*

"*(B) capital expenditures,*

shall be made before the time such equipment is acquired, such

services are offered, substantial expenditures are undertaken in preparation for such offering, or capital expenditures are obligated.

"*(2) The acquisition and offering of only such equipment and services as may be found by the State Agency to be needed; and the obligation of only those capital expenditures found to be needed by the State Agency. Except as otheerwise authorized by this section, review under the program of an application for a certificate of need may not be made subject to any criterion and the issuance of a certificate of need may not be made subject to any condition unless the criterion or condition directly relates to—*

"*(A) criteria prescribed by section 1532(c),*

"*(B) criteria prescribed by regulations of the Secretary promulgated under section 1532(a) before the date of the enactment of the Health Planning and Resources Development Amendments of 1979, or*

"*(C) criteria prescribed by regulation by the State Agency in accordance with an authorization prescribed by State law.*

The Secretary may not require a State to include in its program any criterion in addition to criteria described in subparagraphs (A) and (B).

"*(3) An application for a certificate of need for an institutional health service, medical equipment, or a capital expenditure shall specify the time the applicant will require to make such service or equipment available or to obligate such expenditure and a timetable for making such service or equipment available or obligating such expenditure. After the issuance of a certificate of need, the State Agency shall periodically review the progress of the holder of the certificate in meeting the timetable specified in the approved application for the certificate. If on the basis of such a review the State Agency determines that the holder of a certificate is not meeting such timetable and is not making a good faith effort to meet it, the State Agency may, after considering any recommendation made by the health systems agency which received a report from the State Agency on such review, withdraw the certificate.*

"*(4) In issuing a certificate of need, the State shall specify in the certificate the maximum amount of capital expenditures which may be obligated under such certificate. The program shall, in accordance with regulations promulgated by the Secretary, prescribe the extent to which a project authorized by a certificate of need shall be subject to further review if the amount of capital expenditures obligated or expected to be obligated for the project exceed the maximum specified in the certificate of need.*

"*(5) The program shall provide that (A) the requirements of section 1532 shall apply to proceedings under the program, and (B) each decision to issue a certificate of need (i) may only be issued by the State Agency, and (ii) shall, except in emergency circumstances that pose a threat to public health, be consistent with the State health plan in effect for such State under section 1524(c).*

"(b) (1) *Under the program a State shall not require a certificate of need for the offering of an inpatient institutional health service or the acquisition of major medical equipment or the obligation of a capital expenditure for the provision of an inpatient institutional health service by—*

"(A) *a health maintenance organization or a combination of health maintenance organizations if (i) the organization or combination of organizations has, in the service area of the organization or the service areas of the organizations in the combination, an enrollment of at least 50,000 individuals, (ii) the facility in which the service will be provided is geographically located so that the service will be reasonably accessible to such enrolled individuals, and (iii) at least 75 percent of the patients who can reasonably be expected to receive the institutional health service will be individuals enrolled with such organization or organizations in the combination;*

"(B) *a health care facility which (i) primarily provides inpatient health services, (ii) is controlled directly or indirectly, by a health maintenance organization or a combination of health maintenance organizations which has, in the service area of the organization or service areas of the organizations in the combination, an enrollment of at least 50,000 individuals, (iii) the facility is geographically located so that the service will be reasonably accessible to such enrolled individuals, and (iv) at least 75 percent of the patients who can reasonably be expected to receive the institutional health service will be individuals enrolled with such organization or organizations in the combination, or*

"(C) *a health care facility (or portion thereof) which (i) is leased by a health maintenance organization or combination of health maintenance organizations which has, in the service area of the organization or the service areas of the organizations in the combination, an enrollment of at least 50,000 individuals and on the date the application is submitted under paragraph (2) at least fifteen years remain in the term of the lease, (ii) the facility is geographically located so that the service will be reasonably accessible to such enrolled individuals, and (iii) at least 75 percent of the patients who can reasonably be expected to receive the institutional health service will be individuals enrolled with such organization,*

if, with respect to such offering, acquisition, or obligation, the State Agency has, upon application under paragraph (2), granted an exemption from such requirement to the organization, combination of organizations, or facility.

"(2) *A health maintenance organization, combination of health maintenance organizations, or health care facility shall not be exempt under paragraph (1) from obtaining a certificate of need before offering an institutional health service, acquiring major medical equipment, or obligating capital expenditures unless—*

"(A) it has submitted, at such time and in such form and manner as the State Agency shall prescribe, an application for such exemption,

"(B) the application contains such information respecting the organization, combination, or facility and the proposed offering, acquisition, or obligation as the State Agency may require to determine if the organization, combination, or facility meets the requirements of paragraph (1), and

"(C) the State Agency approves such application.

"(3) Notwithstanding subsection (d), a health care facility (or any part thereof) or medical equipment with respect to which an exemption was granted under paragraph (1) may not be sold or leased and a controlling interest in such facility or equipment or in a lease of such facility or equipment may not be acquired and a health care facility described in subparagraph (C) of paragraph (1) which was granted an exemption under paragraph (1) may not be used by any person other than the lessee described in such subparagraph unless—

"(A) the State Agency issues a certificate of need approving the sale, lease, acquisition, or use, or

"(B) the State Agency determines, upon application, that (i) the entity which the facility or equipment is proposed to be sold or leased or which intends to acquire the controlling interest is a health maintenance organization or a combination of health maintenance organizations which meets the requirements of clause (i) of subparagraph (A) of paragraph (1) and (ii) with respect to such facility or equipment, the entity meets the requirements of clauses (ii) and (iii) of such subparagraph (A).

"(4) Under the program a State may apply its certificate of need requirements to the institutional health services, major medical equipment, and capital expenditures of a health maintenance organization or of a health care facility which is controlled, directly or indirectly, by a health maintenance organization only to the extent that the organization or facility is not exempt under paragraph (1) and then only to the offering of inpatient institutional health services, the acquisition of major medical equipment, and the obligation of capital expenditures.

"(5) Notwithstanding section 1532(c), if a health maintenance organization or a health care facility which is controlled, directly or indirectly, by a health maintenance organization apply for a certificate of need, such application shall be approved by the State Agency if the State Agency finds (in accordance with criteria prescribed by the Secretary by regulation) that—

"(1) approval of such application is required to meet the needs of the members of the health maintenance organization and of the new members which such organization can reasonably be expected to enroll, and

(2) the health maintenance organization is unable to provide, through services or facilities which can reasonably be

expected to be available to the organization, its institutional health services in a reasonable and cost-effective manner which is consistent with the basic method of operation of the organization and which makes such services available on a long-term basis through physicians and other health professionals associated with it.

Except as provided in subsection (b) and notwithstanding subsection (d), a health care facility (or any part thereof) or medical equipment with respect to which a certificate of need was issued under this subsection may not be sold or leased and a controlling interest in such facility or equipment or in a lease of such facility or equipment may not be acquired unless the State Agency issues a certificate of need approving the sale or acquisition or lease.".

"(c) Notwithstanding section 1532(c), an application for a certificate of need for a capital expenditure which is required—

"(1) to eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations,

"(2) to comply with State licensure standards, or

"(3) to comply with accreditation standards compliance with which is required to receive reimbursements under title XVIII of the Social Security Act or payments under a State plan for medical assistance approved under title XIX of such Act,

shall be approved unless the State Agency finds that the facility or service with respect to which such capital expenditure is proposed to be made is not needed or that the obligation of such capital expenditure is not consistent with the State health plan in effect under section 1524. An application for a certificate of need approved under this subsection shall be approved only to the extent that the capital expenditure is required to eliminate or prevent the hazards described in paragraph (1) or to comply with the standards described in paragraph (2) and (3).

"(d)(1) Under the program a certificate of need shall, except as provided in subsection (b), be required for the obligation of a capital expenditure to acquire (either by purchase or under lease or comparable arrangement) an existing health care facility if—

"(A) the notice required by paragraph (2) is not filed in accordance with that paragraph with respect to such acquisition, or

"(B) the State Agency finds, within thirty days after the date it receives a notice in accordance with paragraph (2) with respect to such acquisition, that the services or bed capacity of the facility will be changed in being acquired.

"(2) Before any person enters into a contractual arrangement to acquire an existing health care facility which arrangement will require the obligation of a capital expenditure, such person shall notify the State Agency of the State in which such facility is located of such person's intent to acquire such facility and of the services to be offered in the facility and its bed capacity. Such notice shall be made in writing and shall be made at least thirty days before contractual arrangements are entered into to acquire the facility with respect to which the notice is given.

"(e)(1)(A) Except as provided in subsection (b) and subparagraph (B), under the program a certificate of need shall not be required for

the acquisition of major medical equipment which will not be owned by or located in a health care facility unless—

"(i) the notice required by paragraph (2) is not filed in accordance with that paragraph with respect to such acquisition, or

"(ii) the State Agency finds, within thirty days after the date it receives a notice in accordance with paragraph (2) with respect to such acquisition, that the equipment will be used to provide services for inpatients of a hospital.

"(B) The certificate of need program of a State may include a requirement for a certificate of need for an acquisition of major medical equipment which requirement is in addition to the requirement for a certificate of need established by subparagraph (A), except that after September 30, 1982, the certificate of need program of a State may not be changed to include any such additional requirement.

"(2) Before any person enters into a contractual arrangement to acquire major medical equipment which will not be owned by or located in a health care facility, such person shall notify the State Agency of the State in which such equipment will be located of such person's intent to acquire such equipment and of the use that will be made of the equipment. Such notice shall be made in writing and shall be made at least thirty days before contractual arrangements are entered into to acquire the equipment with respect to which the notice is given.

"(3) For purposes of this subsection, donations and leases of major medical equipment shall be considered acquisitions of such equipment, and an acquisition of medical equipment through a transfer of it for less than fair market value shall be considered an acquisition of major medical equipment if its fair market value is at least $150,000.

"(f) Notwithstanding section 1532(c), when an application is made by an osteopathic or allopathic facility for a certificate of need to construct, expand, modernize, acquire major medical equipment, or add services, the need for that construction, expansion, modernization, acquisition of equipment, or addition of services shall be considered on the basis of the need for and the availability in the community of services and facilities for osteopathic and allopathic physicians and their patients. The State Agency shall consider the application in terms of its impact on existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels.

"(g) In approving or disapproving applications for certificates of need or in withdrawing certificates of need under such a program, a State Agency shall take into account recommendations made by health systems agencies within the State under section 1513(f).".

(b)(1) Section 1523(a)(4)(B) is amended (A) by striking out "new institutional health services proposed to be offered or developed within the State" and inserting in lieu thereof "the obligation of capital expenditures within the State and the offering within the State of new institutional health services and the acquisition of major medical equipment", and (B) by striking out "which is satisfactory to the Secretary" and inserting in lieu thereof "which is consistent with standards established by the Secretary by regulation".

(2) The second sentence of section 1523(a)(4) is amended to read as follows: "A certificate of need program shall provide for procedures and penalties to enforce the requirements of the program.".

(3) Section 1531 is amended (i) by striking out "For purposes of this title" and inserting in lieu thereof "Except as otherwise provided, for purposes of this title", and (ii) by adding after paragraph (5) the following new paragraphs:

"(6) For purposes of sections 1523 and 1527, the term 'capital expenditure' means an expenditure—

"(A) made by or on behalf of a health care facility (as such a facility is defined in regulations prescribed under paragraph (5)); and

"(B)(i) which (I) under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or (ii) is made to obtain by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part; and

"(ii) which (I) exceeds the expenditure minimum (II) substantially changes the bed capacity of the facility with respect to which the expenditure is made, or (III) substantially changes the services of such facility.

For purposes of subparagraph (B)(ii)(I), the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure described in subparagraph (B)(i) is made shall be included in determining if such expenditure exceeds the expenditure minimum. Donations of equipment or facilities to a health care facility which if acquired directly by such facility would be subject to review under section 1527 shall be considered capital expenditures for purposes of sections 1523 and 1527, and a transfer of equipment or facilities for less than fair market value shall be considered a capital expenditure for purposes of such sections if a transfer of the equipment or facilities at fair market value would be subject to review under section 1527. For purposes of this paragraph, the term 'expenditure minimum' means $150,000 for the twelve-month period beginning with the month in which this paragraph is enacted and for each twelve-month period thereafter, $150,000 or, at the discretion of the State, the figure in effect for the preceding twelve-month period, adjusted to reflect the change in the preceding twelve-month period in an index maintained or developed by the Department of Commerce and designated by the Secretary by regulation for purposes of making such adjustment.

"(7) For purposes of sections 1523 and 1527, the term 'major medical equipment' means medical equipment which is used for the provision of medical and other health services and which costs in excess of $150,000, except that such term does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is independent of a physician's office and a hospital and it has been determined under title XVIII of the Social Security Act to meet the requirements of paragraphs (10) and (11) of section 1861(s) of such Act. In determining whether medical equipment has a value in excess of $150,000, the value of studies, surveys, designs, plans, working drawings, specifications, other activities essential to the acquisition of such equipment shall be included.

"(8) *The term 'health maintenance organization' means a public or private organization, organized under the laws of any State, which—*

"(A) *is a qualified health maintenance organization under section 1310(d); or*

"(B)(i) *provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physician services, hospitalization, laboratory, X-ray, emergency and preventive services, and out of area coverage; (ii) is compensated (except for copayments) for the provision of the basic health care services listed in clause (i) to enrolled participants by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health service actually provided; and (iii) provides physicians' services primarily (I) directly through physicians who are either employees or partners of such organizations, or (II) through arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).".*

(4)(A) Section 1522(b)(13) is amended (i) by striking out "(3),", (ii) by inserting "in a timely manner" after "reviewed" in subparagraph (A), and (iii) by inserting after "agencies," in subparagraph (A) the following: "or, if there is no such State law,".

(B) Section 1522(b)(13)(B) is amended by inserting "under subparagraph (A)" after "the reviewing agency".

(5) Section 1532(c)(8) is amended by striking out "for which assistance may be provided under title XIII".

(c) The Comptroller General shall conduct an evaluation of the exemption authority provided by section 1527(b) of the Public Health Service Act. In conducting the evaluation, the Comptroller General shall determine—

(1) the health maintenance organizations, combinations of health maintenance organizations, and health care facilities which have applied to receive an exemption under that section,

(2) the services, facilities, and equipment with respect to which applications have been submitted under that section.

(3) the impact of the exemption on existing contractual arrangements between health maintenance organizations and health care facilities and on plans of such organizations respecting such arrangements, and

(4) the impact of the exemption on health care delivery systems, including its impact on the cost, availability, accessibility, and quality of health care.

The Comptroller General shall report the results of the evaluation to the Committee on Labor and Human Resources of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives not later than February 1, 1982.

(d) Within one hundred and eighty days of the date of the enactment of this Act, the Secretary of Health, Education, and Welfare shall promulgate such regulations as may be necessary to enable the States to establish certificate of need programs which meet the requirements of section 1527 of the Public Health Service Act.

APPROPRIATENESS REVIEW

SEC. 118. (a)(1) Section 1531(g)(1) is amended by striking out "all institutional health services offered in the health service area of the agency" and inserting in lieu thereof "at least those institutional and home health services which are offered in the health service area of the agency and with respect to which goals have been established in the State health plan".

(2) Section 1523(a)(6) is amended by striking out "all institutional health services being offered in the State" and inserting in lieu thereof "all institutional and home health services which are offered in the State and with respect to which goals have been established in the State health plan".

(b)(1) Section 1513(g) is amended by adding at the end the following:

"(3) In making the appropriateness review required by paragraph (1) of a health service, each health systems agency shall at least consider the need for the service, its accessibility and availability, financial viability, cost effectiveness, and the quality of service provided.".

(2) Section 1523(a)(6) is amended by adding at the end the following: "In making the appropriateness review required by this paragraph of a health service, the State Agency shall at least consider the need for the service, its accessibility and availability, financial viability, cost effectiveness, and the quality of service provided."

REVIEW AND APPROVAL OF PROPOSED USES OF FEDERAL FUNDS

SEC. 119. (a) Section 1524(c)(6) is amended—

(1) by striking out "approve or disapprove" in the first sentence and inserting in lieu thereof "recommend approval or disapproval of (A)",

(2) by striking out "or the Comprehensive" in the first sentence and inserting in lieu thereof "section 409 of the Drug Abuse Office and Treatment Act of 1972, or the Comprehensive",

(3) by inserting before the period at the end of the first sentence a comma and the following: "and (B) any application (and any revision of an application) submitted to the Secretary by a State for a grant or contract under any provision of law referred to in clause (A) for projects in more than one health service area of the State",

(4) by amending the third sentence to read as follows: "If a SHCC recommends disapproval of such a plan or application, the Secretary, after making a finding that such plan or application is not in conformity with the State health plan, may not make Federal funds available under such State plan or application.",

(5) by inserting after the third sentence the following new sentence: "If the Secretary makes such a finding, he shall notify the Governor of his finding and the reasons therefor and advise him that he has thirty days in which to submit a revised State plan or application that conforms with the State health plan.", and

(6) by striking out "If after such review" in the last sentence and inserting in lieu thereof the following: "If after reviewing a

recommendation of a SHCC to disapprove such State plan or application,".

(b)(1) Section 1513(e)(1)(A)(i) is amended—

(A) by inserting "of 1972" after "Treatment Act", and

(B) by inserting after "health resources" the following: "by any entity other than the government of a State unless such resources are solely within the health service area of such agency".

(2) Section 1513(e)(1)(A)(ii) is amended by striking out "an allotment" and inserting in lieu thereof "an allotment, contract, or grant".

(3) The first sentence of section 1513(e)(1)(B) is amended by striking out "under title IV, VII, or VIII of this Act" and all that follows in such sentence and inserting in lieu thereof the following: "for research or training unless the grants or contracts are to be made, entered into, or used for the development, expansion, or support of health resources which, in the case of grants or contracts for training, would make a significant change in the health services available in the health service area or which, in the case of grants or contracts for research, would significantly change the delivery of health services, or the distribution or extent of health resources, available to persons in the health service area other than those who are participants in such research.".

(4) Section 1513(e)(2) is amended—

(A) by striking out "such paragraph" in the first sentence and inserting in lieu thereof "paragraph (1)(A)(i)", and

(B) by striking out "If" in the second sentence and inserting in lieu thereof "If under paragraph (1)(A)(i)".

(5) Section 1513(e) is amended by redesignating paragraph (3) as paragraph (4) and by inserting after paragraph (2) the following new paragraph:

"(3) The Governor of a State shall allow health systems agencies sixty days to make the review required by paragraph (1)(A)(ii). If under such paragraph an agency disapproves a proposed use of Federal funds in its health service area, the Governor may not make such Federal funds available for such use until he has made, upon request of the entity making such proposal, a review of the agency decision. In making any such review of any agency decision, the Governor shall give the State health planning and development agency an opportunity to consider the decision of the health systems agency and to submit to the Governor its comments on the decision. The Governor, after taking into consideration such State Agency's comments (if any), may make such Federal funds available for such use, notwithstanding the disapproval of the health systems agency. Each such decision by the Governor to make funds available shall be submitted to the appropriate health systems agency and State health planning and development agency and shall contain a detailed statement of the reasons for the decision.".

COORDINATION OF HEALTH PLANNING WITH RATE REVIEW

SEC. 120. (a) Section 1513(d) is amended (1) by redesignating paragraph (4) as paragraph (5); (2) by striking out "and" in paragraph

(3); and (3) by adding after paragraph (3) the following new paragraph:

"(4) any entity of the State in which the agency is located which reviews the rates or budgets of health care facilities located in the agency's health service area, and".

(b) Section 1522(b)(7)(A) is amended by inserting before the comma at the end the following: "and for the coordination by the State Agency in the conduct of its activities with any entity of the State which reviews the rates or budgets of health care facilities in the State".

(c)(1) Section 1526 is amended—

(A) by striking out "(not later than six months after the date of the enactment of this title)" in the first sentence of subsection (a); and

(B) by striking out the last sentence of subsection (a).

(2) Such section is further amended—

(A) by inserting before the period in the first sentence of subsection (a) "or to any other entity of the government of a State which has so indicated an intent to regulate such rates";

(B) by striking out "A State Agency" in subsection (b)(1) and inserting in lieu thereof "An entity";

(C) by striking out "the State Agency" in subparagraphs (A) and (F) of such subsection and inserting in lieu thereof "the entity";

(D) by inserting "if it is a State Agency," after "(D)" and "(E)", respectively, in such subsection;

(E) by adding after and below subparagraph (G) of such subsection the following: "If an entity which is not a State Agency receives a grant under subsection (a), such entity shall coordinate its activities under the grant with the State Agency for the State in which such entity is located, share with the State Agency data obtained from such activities, and for purposes of such activities, develop with the State Agency criteria for the review of institutional health services, equipment, and facilities which guidelines are not in conflict with criteria adopted by the State Agency.";

(F) by striking out "a State Agency" in subsection (b)(2) and inserting in lieu thereof "an entity" and by striking out "the State Agency" in such subsection and inserting in lieu thereof "the entity"; and

(G) by striking out "State Agency" in subsection (d) and in the first sentence of subsection (c) and inserting in lieu thereof "entity".

COORDINATION WITHIN STANDARD METROPOLITAN STATISTICAL AREAS AND WITH OTHER ENTITIES

SEC. 121. (a) Section 1513(d) is amended (1) by inserting "(including area agencies on aging and local and regional alcohol abuse, drug abuse, and mental health planning agencies)" after "administrative agencies" in paragraph (3).

(b) Subsection (d) of section 1513 (as amended by section 120(a)) is amended (1) by inserting "(1)" after "(d)", (2) by redesignating paragraphs (1), (2), (3), (4), and (5) as subparagraphs (A), (B), (C), (D), and (E), respectively, and (3) by adding at the end the following:

"(2) Each health systems agency which has all or part of its health service area within a part of a standard metropolitan statistical area (as determined by the Office of Management and Budget) shall coordinate its activities with the activities of any other health systems agency which has any part of its health service area within such standard metropolitan statistical area. Such coordination shall at least provide that each health systems agency designated for a health service area within any part of a single standard metropolitan statistical area shall review (A) each HSP and AIP for each such health service area, (B) the criteria used in accordance with section 1532 for reviews affecting any such area, and (C) each decision under certificate of need programs which affect any such area.

"(3) The Secretary shall by regulation provide for the sharing by health systems agencies of health planning data with Indian tribes and Alaska Native Villages.

"(4) Health systems agencies that have an Indian tribe or intertribal Indian organization (referred to in subsection (e)(1)(B)) located within such agencies' health service areas shall carry out their functions under this section in a manner that recognizes tribal self-determination. Such agencies shall seek to enter into agreements with the Indian tribes and intertribal organizations located within their health service areas on matters of mutual concern as defined in regulations of the Secretary.".

(c) Section 1513(e) is amended by inserting "as defined in section 4(b) of the Indian Self-Determination and Education Assistance Act)" after "Indian tribe" in paragraph (1)(B).

COLLECTION AND PUBLICATION OF HOSPITAL CHARGES

SEC. 122. (a) Subsection (h) of section 1513 is amended to read as follows:

"(h)(1) Each health systems agency shall collect annually on a form developed in consultation with the State health planning and development agency (or agencies) the rates charged for each of the twenty-five most frequently used hospital services in the State (or States) including the average semiprivate and private room rates.

"(2) Each health systems agency shall make available to the public for inspection and copying (at a reasonable expense to the public) the information supplied to the health systems agency pursuant to this subsection in readily understandable language and in a manner designed to facilitate comparisons among the hospitals in the health systems agency's health service area.".

(b) Section 1522(b)(5) is amended by adding before the semicolon the following: "and contain provisions to assure compliance with requests for information made by health systems agencies in accordance with section 1513(h)".

STATE HEALTH PLANNING AND DEVELOPMENT AGENCIES

SEC. 123. (a) Section 1521(b)(4) is amended (1) by inserting "(A)" after "(4)"; (2) by inserting "upon a review under section 1535 of the State Agency's operation and performance of its function" before "he determines"; (3) by adding at the end of paragraph (4) the following: "Before renewing an agreement under this paragraph with a State Agency for a State, the Secretary shall provide each health systems agency designated for a health service area located (in whole or in part) in such State and the Statewide Health Coordinating Council of such State an opportunity to comment on the performance of the State Agency and to provide a recommendation on whether such agreement should be renewed."; and (4) adding at the end thereof the following new subparagraph:

"(B) If upon a review under section 1535 of the State Agency's operation and performance of its functions, the Secretary determines that it has not fulfilled, in a satisfactory manner, the responsibilities of a State Agency during the period of the agreement to be renewed or if the applicable State administrative program does not continue to meet the requirements of section 1522, he may terminate such agreement or return the State Agency to a conditionally designated status under paragraph (2) of subsection (b) for a period not to exceed twelve months. At the end of such period, the Secretary shall either terminate its agreement with such State Agency or enter into an agreement with such State Agency under paragraph (3) of subsection (b). The Secretary may not take the action authorized by the first sentence of this subparagraph unless the Secretary has—

"(i) provided the State Agency with notice of his intent to return it to a conditional status or terminate the agreement with it and included in that notice specification of any functions which the Secretary has determined the State Agency did not satisfactorily fulfill and of any requirements which the Secretary has determined it has not met;

"(ii) provided the State Agency with a reasonable opportunity for a hearing, before an officer or employee of the Department of Health, Education, and Welfare designated for such purpose, on the action proposed to be taken by the Secretary; and

"(iii) in the case of a proposed termination, consulted with the National Council on Health Planning and Development respecting the termination.".

(b)(1)(A) Paragraphs (3) and (4) of section 1521(b) are each amended by striking out "twelve months" and inserting in lieu thereof "thirty-six months".

(B) The amendments made by subparagraph (A) shall apply with respect to designation agreements entered into under section 1521(b)(3) of the Public Health Service Act after the date of the enactment of this Act.

(2) Section 1521(b)(3) is amended—

(A) by inserting "(A)" after "(3)",

(B) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively,

(C) by amending clause (ii) (as so redesignated) to read as follows:

"(ii) by the Secretary if the Secretary determines, in accordance with subparagraph (B), that the designated State Agency is not complying with the provisions of such agreement.", and

(D) by adding at the end the following:

"(B) Before the Secretary may terminate an agreement with a designated State Agency under subparagraph (A)(ii), the Secretary shall—

"(i) consult with the Statewide Health Coordinating Council of the State for which the State Agency is designated respecting the proposed termination,

"(ii) give the State Agency notice of the intention to terminate the agreement and in the notice specify with particularity (I) the basis for the determination of the Secretary that the State Agency is not in compliance with the agreement, and (II) the actions that the State Agency should take to come into compliance with the agreement, and

"(iii) provide the State Agency with a reasonable opportunity for a hearing, before an officer or employee of the Department of Health, Education, and Welfare designated for such purpose, on the matter specified in the notice.

The Secretary may not terminate such an agreement before consulting with the National Council on Health Planning and Development respecting the proposed determination. Before the Secretary may permit the term of an agreement to expire without renewing the agreement, the Secretary shall make the consultations prescribed by clause (i) and the preceding sentence, give the State Agency with which the agreement was made notice of the intention not to renew the agreement and the reasons for not renewing the agreement, and provide, as prescribed by clause (iii), the State Agency an opportunity for a hearing on the matter specified in the notice.".

(c)(1)(A) Section 1522(b)(13) is amended by striking out ", (g), or (h)" and inserting in lieu thereof "or (g)".

(B) Section 1513(a) is amended by striking out "through (h)" and inserting in lieu thereof "through (g)".

(2) Paragraph (3) of section 1523(a) is amended by striking out "review of the State medical facilities plan required under section 1603, and in the".

(3) Section 1523(a) is amended by adding after paragraph (6) the following new paragraph:

"(7) Prepare an inventory of the health care facilities (other than Federal health care facilities) located in the State and evaluate on an ongoing basis the physical condition of such facilities. Such inventory and evaluations shall be reported to the health systems agencies designated for health service areas located (in whole or in part) in the State for purposes of the functions of the agency under section 1513(b).".

(d) Subsection ADQ of section 1521 is amended to read as follows:

"(d)(1) If an agreement under subsection (b)(3) for the designation of a State Agency for a State is not in effect upon the expiration of—

"(A) the fourth fiscal year which begins after the calendar year in which the National Health Planning and Resources Development Act of 1974 is enacted; or

"(B) (i) if the legislature of the State is in a regular session on the date of the enactment of the Health Planning and Resources Development Amendments of 1979 and the legislature will be in session for at least twelve months from such date, or

"(ii) if the legislature of the State is in session on such date of enactment but twelve months do not remain in such session after such date or if the legislature of the State is not in session on such date, twelve months after the beginning of the first regular session of the legislature beginning after such date,

whichever occurs later, the Secretary shall take the action prescribed by paragraph (2).

"(2) If upon the expiration of the period applicable under paragraph (1) an agreement is not in effect for the designation of a State Agency for a State, the Secretary shall until such an agreement is in effect take the following action:

"(A) During the first twelve months after the date of the expiration of the applicable period, the Secretary shall reduce by 25 percent the amount of each allotment, grant, loan, and loan guarantee made to and each contract entered into with an individual or entity in such State during such period under this Act, the Community Mental Health Centers Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, and the Drug Abuse Office and Treatment Act of 1972.

"(B) During the second twelve months after such expiration date, the Secretary shall reduce by 50 percent the amount of each such allotment, grant, loan, loan guarantee, and contract.

"(C) During the third twelve months after such expiration date, the Secretary shall reduce by 75 percent the amount of each such allotment, grant, loan, loan guarantee, and contract.

"(D) After the expiration of thirty-six months after such expiration date, the Secretary may not make or enter into any such allotment, grant, loan, loan guarantee, or contract.".

(e) (1) Section 1522(c) is amended by striking out "once each year" and inserting in lieu thereof "once every three years".

(2) Section 1523(a) (as amended by subsection (c) (3)) is amended by adding the following new paragraph at the end thereof:

"(8) Provide technical assistance to individuals and public and private entities in obtaining and filling out the necessary forms for the development of projects and programs.".

(f) The first sentence of section 1521(b) (2) (B) is amended by inserting before the period a comma and the following: "except that the Secretary may extend the period for such additional time as he finds appropriate if he finds that the designated State Agency is making a good faith effort to comply with the requirements of section 1523".

(g) (1) Paragraph (5) of section 1523(a) is amended by striking out "1413(f)" and inserting in lieu thereof "1513(f)".

(2) Section 1521(b) (1) is amended by striking out "this part" and inserting in lieu thereof "this title".

STATEWIDE HEALTH COORDINATING COUNCIL COMPOSITION

SEC. 124. (a) (1) Section 1524(b) (1) (A) (ii) is amended by inserting before the period a comma and the following: "except that the number of representatives on the SHCC to which a health systems agency designated for a health service area which is not entirely within the State shall be a number which is based on the relationship of the population of the portion of such health service area within the State to the population of the largest health service area located entirely within the State, except that each such agency shall be entitled to at least one representative on the SHCC".

(2) Section 1524(b) (1) (A) (iii) is amended to read as follows:

"(iii) Except as otherwise provided in clause (ii) and this clause, each such health systems agency shall be entitled to at least two representatives on the SHCC. If there are more than ten health systems agencies within a State, each health systems agency within such State shall be entitled to at least one representative on the SHCC. Of the representatives of health systems agencies on the SHCC, not less than one-half shall be individuals who are consumers of health care and who are not providers of health care.".

(3) Section 1524(b) (1) (A) (i) is amended (A) by inserting "(or if the number of representatives on the SHCC to which health systems agencies are entitled under the second sentence of clause (iii) is less than sixteen, no fewer than the number to which they are entitled)" after "sixteen representatives", (B) by striking out "at least five", and (C) by adding at the end the following: "Each agency shall submit a number of nominees to the Governor which is at least twice the number of representatives on the SHCC to which the agency is entitled.".

(4) Section 1524(b) (1) is amended by adding at the end thereof the following new paragraph:

"(E) Members of the SHCC who are consumers of health care and who are not providers of health care shall include individuals who represent rural and urban medically underserved populations if such populations exist in the State."

(b) Section 1524(b) (2) is amended to read as follows:

"(2) The Governor may select, by and with the advice and consent of the State senate, or, in the case of a State with a unicameral legislature, of the State legislature, the chairman of the SHCC from among the members of the SHCC. If the Governor does not select the chairman, the SHCC shall select the chairman from among its members.".

(c) (1) Section 1524(b) (1) (C) is amended by striking out "one-third" and inserting in lieu thereof "one-half".

(2) Section 1524(b) (1) (D) is amended by striking out "two" and inserting in lieu thereof "one".

(d) The first sentence of section 1524(c) (2) (B) is amended by striking out "State agency" and inserting in lieu thereof "State Agency".

CENTERS FOR HEALTH PLANNING

SEC. 125. (a) Section 1534(b) (1) is amended (1) by inserting "and it will be able to provide assistance and dissemination of information to health systems agencies and State Agencies as provided in subsec-

tions (a) and (c)," after "paragraph (2)", and (2) by inserting "and is able to provide such assistance and dissemination of information" after "such requirements".

(b) Clause (2) of section 1534(c) is amended to read as follows: "(2) shall develop and use methods (satisfactory to the Secretary) to disseminate to such agencies and State Agencies planning approaches, methodologies (including methodologies to provide for education of new board members and new staff and continuing education of board members and staff of such agencies and State Agencies), policies, and standards.".

DEFINITIONS

SEC. 126. (a) (1) Section 1531(5) is amended to read as follows:

"(5) The term 'institutional health services' means health services which (A) are provided through private and public hospitals, rehabilitation facilities, nursing homes, and other health care facilities, as defined by the Secretary by regulation, and (B) entail annual operating costs of at least $75,000. For purposes of this paragraph, the term 'expenditure minimum' means $75,000 for the twelve-month period beginning with the month in which this paragraph is enacted and for each twelve-month period thereafter, $75,000 or, at the discretion of the State, the figure in effect for the preceding twelve-month period, adjusted to reflect the change in the preceding twelve-month period in an index maintained or developed by the Department of Commerce and designated by the Secretary by regulation for purposes of making such adjustment.".

(2) After the date of the enactment of this Act, the Secretary shall consult with the Committee on Labor and Human Resources of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives before promulgating regulations defining health care facilities for purposes of section 1531(5) of the Public Health Service Act as amended by paragraph (1).

(b) Section 1531 is amended by adding after paragraph (8) (added by section 117 of this Act) the following new paragraphs:

"(9) For purposes of sections 1523(a)(4)(B), 1527, and 1531(5), the term 'rehabilitation facility' means an inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services which are provided under competent professional supervision. For purposes of the remaining provisions of this title, the term 'rehabilitation facility' means an inpatient facility described in the preceding sentence and, in addition, an outpatient facility which is operated as described in such sentence.

"(10) The term 'medically underserved population' has the same meaning as such term has under section 330(b)(3).

"(11) Any reference to the term 'health' includes physical and mental health.

"(12) The term 'physician' means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by a State.".

AUTHORIZATIONS

SEC. 127. (a) Section 1516(d)(1) (as amended by section 106) is amended—

(1) by striking out "and" after "1976,", and

(2) by inserting before the period the following: ", $150,000,000 for the fiscal year ending September 30, 1980, $165,000,000 for the fiscal year ending September 30, 1981, and $185,000,000 for the fiscal year ending September 30, 1982".

(b) Section 1525(c) is amended—

(1) by striking out "and" after "1976,", and

(2) by inserting before the period the following: ", $35,000,000 for the fiscal year ending September 30, 1980, $40,000,000 for the fiscal year ending September 30, 1981, and $45,000,000 for the fiscal year ending September 30, 1982".

(c) Section 1526(e) is amended—

(1) by striking out "and" after "1976,", and

(2) by inserting before the period the following: ", $6,000,000 for the fiscal year ending September 30, 1980, $6,000,000 for the fiscal year ending September 30, 1981, and $6,000,000 for the fiscal year ending September 30, 1982".

(d) Section 1534(d) is amended—

(1) by striking out "and" after "1976,", and

(2) by inserting before the period the following: ", $6,000,000 fiscal year ending September 30, 1981, and $10,000,000 for the fiscal year ending September 30, 1982".

(e) Section 1640(d) is amended—

(1) by striking out "and" after "1976,", and

(2) by inserting before the period the following: ", $20,000,000 for the fiscal year ending September 30, 1981, and $30,000,000 for the fiscal year ending September 30, 1982".

TECHNICAL AMENDMENT

SEC. 128. Section 1903(m)(2)(C) of the Social Security Act is amended by striking out "the date the entity enters into a contract with the State under this title for the provision of health services on a prepaid risk basis" and inserting in lieu thereof "the date the entity qualifies as a health maintenance organization (as determined by the Secretary)".

EFFECTIVE DATE

SEC. 129. (a) The amendments made by this title (other than by sections 101, 102, 103, 104(c), 105(d), 106, 107, 117, 123(b), 127, and 128) shall take effect one year after the date of the enactment of this Act, except that on and after the date of the enactment of this Act—

(1) the changes in the membership of the health systems agencies and the Statewide Health Coordinating Councils required by amendments to sections 1512, 1524, and 1531 shall be implemented through selections of members to fill vacancies occurring after such date,

(2) a health systems agency, a State health planning and development agency, and a Statewide Health Coordinating Council may make the organizational and related changes required by the amendments to sections 1512, 1522, 1523, 1524, and 1531 of the Public Health Service Act, and

(3) health systems agencies, State health planning and development agencies, and Statewide Health Coordinating Councils

may act in accordance with the changes in their functions made by the amendments to sections 1513, 1522, 1523, 1524, and 1532 of the Public Health Service Act.

(b)(1) Except as provided in section 1516(c)(1)(C)(i) of the Public Health Service Act as amended by section 106, the amendments made by section 106 shall apply with respect to grants made under section 1516 of the Public Health Service Act after the date of the enactment of this Act from appropriations under an appropriation Act enacted for the fiscal year ending September 30, 1980.

(2) The amendments made by section 117 shall take effect on the enactment of this Act, except that if the Secretary of Health, Education, and Welfare determines that any amendment made by such section will require a State to change its laws before the State health planning and development agency designated for such State may perform its functions under section 1523(a)(4)(B) of the Public Health Service Act, such amendment shall take effect in such State—

(A) if the legislature of the State is in a regular session on the date of the enactment of the Health Planning and Resources Development Amendments of 1979 and the legislature will be in session for at least twelve months from such date, twelve months from such date, or

(B) if the legislature of the State is in session on such date of enactment but twelve months do not remain in such session after such date or if the legislature of the State is not in sesion on such date, twelve months after the beginning of the first regular session of the legislature beginning after such date.

TITLE II—REVISION OF AUTHORITY FOR HEALTH RESOURCES DEVELOPMENT

REVISION AND EXTENSION OF ASSISTANCE

SEC. 201. (a) Part B of title XVI is repealed.

(b)(1) Subsections (a) and (b) of section 1620 are amended to read as follows:

"(a)(1) The Secretary, during the period ending September 30, 1982, may, in accordance with this part, make loans from the fund established under section 1622(d) to any public or nonprofit private entity for projects for—

"(A) the discontinuance of unneeded hospital services or facilities,

"(B) the conversion of unneeded hospital services and facilities to needed health services and medical facilities, including outpatient medical facilities and facilities for long-term care;

"(C) the renovation and modernization of medical facilities, particularly projects for the prevention or elimination of safety hazards, projects to avoid noncompliance with licensure or accreditation standards, or projects to replace obsolete facilities;

"(D) the construction of new outpatient medical facilities; and

"(E) the construction of new inpatient medical facilities in areas which have experienced (as determined by the Secretary) recent rapid population growth.

"(2)(A) *The Secretary, during the period ending September 30, 1982, may, in accordance with this part, guarantee to—*

"(i) *non-Federal lenders for their loans to public and nonprofit private entities for medical facilities projects described in paragraph (1), and*

"(ii) *the Federal Financing Bank for its loans to public and nonprofit private entities for such projects.*

payment of principal and interest on such loans.

"(B) *In the case of a guarantee of any loan to a public or nonprofit private entity under subparagraph (A)(i) which is located in an urban or rural poverty area, the Secretary may pay, to the holder of such loan and for and on behalf of the project for which the loan was made, amounts sufficient to reduce by not more than one half the net effective interest rate otherwise payable on such loan if the Secretary finds that without such assistance the project could not be undertaken.*

"(b) *The principal amount of a loan directly made or guaranteed under subsection (a) for a medical facilities project, when added to any other assistance provided such project under part B, may not exceed 90 per centum of the cost of such project unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the principal amount, when added to other assistance under part B, may cover up to 100 per centum of such costs.".*

(2) *Section 1622(b)(2)(D) is amended by striking out "minus 3 per centum per annum" and inserting in lieu thereof the following: "minus any interest subsidy made in accordance with section 1620(b)(2) with respect to a loan made for a project located in an urban or rural poverty area".*

(3) *Section 1622(e)(2) is amended (A) by striking out "and" after "1977," and (B) by inserting before the period a comma and the following: "September 30, 1979, September 30, 1980, September 30, 1981, and September 30, 1982".*

(c) *Section 1625 is amended to read as follows:*

"PROJECT GRANTS

"SEC. *1625. (a)(1)(A) The Secretary may make grants for construction or modernization projects designed to—*

"(i) *eliminate or prevent in medical facilities imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, or*

"(ii) *avoid noncompliance by medical facilities with State or voluntary licensure or accreditation standards.*

"(B) *A grant under subparagraph (A) may only be made to—*

"(i) *a State or political subdivision of a State, including any city, town, county, borough, hospital district authority, or public or quasi-public corporation, for any medical facility owned or operated by the State or political subdivision; and*

"(ii) *a nonprofit private entity for any medical facility owned or operated by the entity but only if the Secretary determines—*

"(I) *the level of community service provided by the facility and the proportion of its patients who are unable to pay for services rendered in the facility is similar to such level and proportion in a medical facility of a State or political subdivision, and*

"(II) that without a grant under subparagraph (A) there would be a disruption of the provision of health care to low-income individuals.

"(2) The amount of any grant under paragraph (1) may not exceed 75 per centum of the cost of the project for which the grant is made unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the grant may cover up to 100 per centum of such costs.

"(3) There are authorized to be appropriated for grants under paragraph (1) $40,000,000 for the fiscal year ending September 30, 1980, $50,000,000 for the fiscal year ending September 30, 1981, and $50,000,000 for the fiscal year ending September 30, 1982. Funds available for obligation under this subsection (as in effect before the date of the enactment of the Health Planning and Resources Development Amendments of 1979) in the fiscal year ending September 30, 1979, shall remain available for obligation under this subsection in the succeeding fiscal year.

"(b)(1) The Secretary may make grants to public and nonprofit private entities for projects for (A) construction or modernization of outpatient medical facilities which are located apart from hospitals and which will provide services for medically underserved populations, and (B) conversion of existing facilities into outpatient medical facilities or facilities for long-term care to provide services for such populations.

"(2) The amount of any grant under paragraph (1) may not exceed 80 per centum of the cost of the project for which the grant is made unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the grant may cover up to 100 per centum of such costs.

"(3) There are authorized to be appropriated for grants under paragraph (1) $15,000,000 for the fiscal year ending September 30, 1981, and $15,000,000 for the fiscal year ending September 30, 1982.".

CONFORMING AMENDMENTS

SEC. 202. (a) Part A of title XVI is repealed and parts C, D, E, and F of title XVI are redesignated as parts A, B, C, and D, respectively.

(b) Part C (as so redesignated) of title XVI is amended by striking out section 1630, by redesignating section 1631 through 1635 as section 1622 through 1626, respectively, and by inserting before section 1622 (as so redesignated) the following:

"GENERAL REGULATIONS

"SEC. 1620. The Secretary shall by regulation—

"(1) prescribe the manner in which he shall determine the priority among projects for which assistance is available under part A or B, based on the relative need of different areas for such projects and giving special consideration—

"(A) to projects for medical facilities serving areas with relatively small financial resources and for medical facilities serving rural communities,

"(B) in the case of projects for modernization of medical facilities, to projects for facilities serving densely populated areas,

"(C) in the case of projects for construction of outpatient medical facilities, to projects that will be located in, and provide services for residents of, areas determined by the Secretary to be rural or urban poverty areas,

"(D) to projects designed to (i) eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, or (ii) avoid noncompliance with State or voluntary licensure or accreditation standards, and

"(E) to projects for medical facilities which, alone or in conjunction with other facilities, will provide comprehensive health care, including out-patient and preventive care as well as hospitalization;

"(2) prescribe for medical facilities projects assisted under part A or B general standards of construction, modernization, and equipment, which standards may vary on the basis of the class of facilities and their location; and

"(3) prescribe the general manner in which each entity which receives financial assistance under part A or B or has received financial assistance under part A or B or title VI shall be required to comply with the assurances required to be made at the time such assistance was received and the means by which such entity shall be required to demonstrate compliance with such assurances.

An entity subject to the requirements prescribed pursuant to paragraph (3) respecting compliance with assurances made in connection with receipt of financial assistance shall submit periodically to the Secretary data and information which reasonably supports the entity's compliance with such assurances. The Secretary may not waive the requirement of the preceding sentence.

"APPLICATIONS

"SEC. 1621. (a) No loan, loan guarantee, or grant may be made under part A or B for a medical facilities project unless an application for such project has been submitted to and approved by the Secretary. If two or more entities join in a project, an application for such project may be filed by any of such entities or by all of them.

"(b)(1) An application for a medical facilities project shall be submitted in such form and manner as the Secretary shall by regulation prescribe and shall, except as provided in paragraph (2), set forth—

"(A) in the case of a modernization project for a medical facility for continuation of existing health services, a finding by the State Agency of a continued need for such services, and, in the case of any other project for a medical facility, a finding by the State Agency of the need for the new health services to be provided through the medical facility upon completion of the project;

"(B) in the case of an application for a grant, assurances satisfactory to the Secretary that (i) the applicant making the application would not be able to complete the project for which the

application is submitted without the grant applied for, and (ii) in the case of a project to construct a new medical facility, it would be inappropriate to convert an existing medical facility to provide the services to be provided through the new medical facility;

"(C) in the case of a project for the discontinuance of a service or facility or the conversion of a service or a facility, an evaluation of the impact of such discontinuance or conversion on the provision of health care in the health service area in which such service was provided or facility located;

"(D) a description of the site of such project;

"(E) plans and specifications therefor which meet the requirements of the regulations prescribed under section 1620(2);

"(F) reasonable assurance that title to such site is or will be vested in one or more of the entities filing the application or in a public or other nonprofit entity which is to operate the facility on completion of the project;

"(G) reasonable assurance that adequate financial support will be available for the completion of the project and for its maintenance and operation when completed, and, for the purpose of determining if the requirements of this subparagraph are met, Federal assistance provided directly to a medical facility which is located in an area determined by the Secretary to be an urban or rural poverty area or through benefits provided individuals served at such facility shall be considered as financial support;

"(H) the type of assistance being sought under part A or B for the project;

"(I) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on a project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a–5, known as the Davis-Bacon Act), and the Secretary of Labor shall have with respect to such labor standards the authority and functions set forth in Reorganization Plan numbered 14 of 1950 (15 FR 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c);

"(J) in the case of a project for the construction or modernization of an outpatient facility, reasonable assurance that the services of a general hospital will be available to patients at such facility who are in need of hospital care; and

"(K) reasonable assurance that at all times after such application is approved (i) the facility or portion thereof to be constructed, modernized, or converted will be made available to all persons residing or employed in the area served by the facility, and (ii) there will be made available in the facility or portion thereof to be constructed, modernized, or converted a reasonable volume of services to persons unable to pay therefor and the Secretary, in determining the reasonableness of the volume of services provided, shall take into consideration the extent to which compliance is feasible from a financial viewpoint.

"(2)(A) The Secretary may waive—

"(i) the requirements of subparagraph (D) of paragraph (1) for compliance with modernization and equipment standards prescribed pursuant to section 1620(2), and

"(*ii*) *the requirement of subparagraph* (*E*) *of paragraph* (*1*) *respecting title to a project site,*

in the case of an application for a project described in subparagraph (*B*) *of this paragraph.*

"(*B*) *A project referred to in subparagraph* (*A*) *is a project—*

"(*i*) *for the modernization of an outpatient medical facility which will provide general purpose health services, which is not part of a hospital, and which will serve a medically underserved population as defined in section 1624 or as designated by a health systems agency, and*

"(*ii*) *for which the applicant seeks a loan under part A the principal amount of which does not exceed $20,000.*".

(*c*) *Part C* (*as so redesignated*) *of title XVI is amended by adding at the end thereof the following new section:*

"*ENFORCEMENT OF ASSURANCES*

"*SEC. 1627. The Secretary shall investigate and ascertain, on a periodic basis, with respect to each entity which is receiving financial assistance under this title or which has received financial assistance under title VI or this title, the extent of compliance by such entity with the assurances required to be made at the time such assistance was received. If the Secretary finds that such an entity has failed to comply with any such assurance, the Secretary shall report such noncompliance to the health systems agency for the health service area in which such entity is located and the State health planning and development agency of the State in which the entity is located and shall take any action authorized by law (including an action for specific performance brought by the Attorney General upon request of the Secretary) which will effect compliance by the entity with such assurances. An action to effectuate compliance with any such assurance may be brought by a person other than the Secretary only if a complaint has been filed by such person with the Secretary and the Secretary has dismissed such complaint or the Attorney General has not brought a civil action for compliance with such assurance within six months after the date on which the complaint was filed with the Secretary.*".

TECHNICAL AMENDMENTS

SEC. 203. (*a*) *Part A* (*as so redesignated*) *of title XVI is amended—*

(*1*) *by striking out section 1621 and by redesignating sections 1620 and 1622 as sections 1601 and 1602, respectively,*

(*2*) *by striking out "section 1622*(*d*)*" in subsection* (*a*)(*1*) *of section 1601* (*as so redesignated*) *and inserting in lieu thereof "section 1602*(*d*)*", and*

(*3*) *by striking out "section 1620*(*b*)(*2*)*" each place it occurs in subsection* (*d*) *of section 1602* (*as so redesignated*) *and inserting in lieu thereof "section 1601*(*a*)(*2*)(*B*)*".*

(*b*) *Section 1625 of part B* (*as so redesignated*) *is redesignated as section 1610.*

(*c*) *Subsection* (*a*)(*1*) *of section 1622* (*as so redesignated*) *is amended by striking out "section 1604" and inserting in lieu thereof "section 1621".*

(d) Section 1623 (as so redesignated) is amended by striking out "STATE" in the heading for such section.

(e) Section 1624 (as so redesignated) is amended by striking out paragraphs (1) and (2) and by redesignating paragraphs (3) through (16) as paragraphs (1) through (14), respectively.

(f) Section 1626 (as so redesignated) is amended by striking out "section 1604" and inserting in lieu thereof "section 1621".

(g)(1) Section 1602 (as so redesignated) is amended by adding at the end thereof the following:

"(f)(1) The Secretary may take such action as may be necessary to prevent a default on a loan made or guaranteed under this part or under title VI, including the waiver of regulatory conditions, deferral of loan payments, renegotiation of loans, and the expenditure of funds for technical and consultative assistance, for the temporary payment of the interest and principal on such a loan, and for other purposes. Any such expenditure made under the preceding sentence on behalf of a medical facility shall be made under such terms and conditions as the Secretary shall prescribe, including the implementation of such organizational, operational, and financial reforms as the Secretary determines are appropriate and the disclosure of such financial or other information as the Secretary may require to determine the extent of the implementation of such reforms.

"(2) The Secretary may take such action, consistent with State law, respecting foreclosure procedures as he deems appropriate to protect the interest of the United States in the event of a default on a loan made or guaranteed under this part or under title VI, including for a reasonable period of time taking possession of, holding, and using real property pledged as security for such a loan or loan guarantee.".

(2) Paragraph (1) of subsection (d) is amended (A) by striking out "and" at the end of subparagraph (D), (B) by striking out the period at the end of subparagraph (E) and inserting in lieu thereof ", and", and (C) by adding after subparagraph (E) the following:

"(F) to enable the Secretary to take the action authorized by subsection (f).".

(3) Paragraph (2) of subsection (d) is amended (A) by striking out "and" at the end of subparagraph (D), (B) by inserting "and" at the end of subparagraph (E), and (C) by adding after subparagraph (E) the following:

"(F) to enable the Secretary to take the action authorized by subsection (f),".

EFFECTIVE DATE

SEC. 204. The amendments made by this title shall take effect October 1, 1979, except that the amendments made by section 201(b) respecting the payment of an interest subsidy for a loan or loan guarantee made under part A of title XVI of the Public Health Service Act shall apply only with respect to loans and loan guarantees made after October 1, 1979, and with respect to loans and loan guarantees made under such part before such date the Secretary shall continue to pay the interest subsidy authorized for such loans and loan guarantees before such date.

TITLE III—PROGRAM TO ASSIST AND ENCOURAGE THE DISCONTINUANCE OF UNNEEDED HOSPITAL SERVICES

AUTHORIZATION OF PROGRAM

SEC. 301. (a) Title XVI, as amended by title II of this Act, is amended by adding at the end the following new part:

"PART E—PROGRAM TO ASSIST AND ENCOURAGE THE VOLUNTARY DISCONTINUANCE OF UNNEEDED HOSPITAL SERVICES AND THE CONVERSION OF UNNEEDED HOSPITAL SERVICES TO OTHER HEALTH SERVICES NEEDED BY THE COMMUNITY

"ESTABLISHMENT OF PROGRAM

"SEC. 1641. The Secretary shall, by April 1, 1980, establish a program under which—

"(1) grants and technical assistance may be provided to hospitals in operation on the date of the enactment of this part (A) for the discontinuance of unneeded hospital services, and (B) for the conversion of unneeded hospital services to other health services needed by the community; and

"(2) grants may be provided to State Agencies designated under section 1521(b)(3) for reducing excesses in resources and facilities of hospitals.

"GRANTS FOR DISCONTINUANCE AND CONVERSION

"SEC. 1642. (a)(1) A grant to a hospital under the program shall be subject to such terms and conditions as the Secretary may by regulation prescribe to assure that the grant is used for the purpose for which it was made.

"(2) The amount of any such grant shall be determined by the Secretary. The recipient of such a grant may use the grant—

"(A) in the case of a grantee which discontinues the provision of all inpatient hospital services or an identifiable part of a hospital facility which provides inpatient hospital services, for the liquidation of the outstanding debt on the facilities of the grantee used for the provision of the services or for the liquidation of the outstanding debt of the grantee on such identifiable part;

"(B) in the case of a grantee which in discontinuing the provision of an inpatient hospital service converts or proposes to convert an identifiable part of a hospital facility used in the provision of the discontinued service to the delivery of another health service, for the planning, development (including construction and acquisition of equipment), and delivery of the health service;

"(C) to provide reasonable termination pay for personnel of the grantee who will lose employment because of the discontinuance of hospital services made by the grantee, retraining of such personnel, assisting such personnel in securing employment, and other costs of implementing arrangements described in subsection (c); and

"(D) for such other costs which the Secretary determines may need to be incurred by the grantee in discontinuing hospital services.

"(b)(1) No grant may be made to a hospital unless an application therefor is submitted to and approved by the Secretary. Such an application shall be in such form and submitted in such manner as the Secretary may prescribe and shall include—

"(A) a description of each service to be discontinued and, if a part of a hospital is to be discontinued or converted to another use in connection with such discontinuance, a description of such part;

"(B) an evaluation of the impact of such discontinuance and conversion on the provision of health care in the health service area in which such service is provided;

"(C) an estimate of the change in the applicant's costs which will result from such discontinuance and conversion; and

"(D) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on a project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a–276a5, known as the Davis-Bason Act), and the Secretary of Labor shall have with respect to such labor standards the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 FR 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c);

"(E) such other information as the Secretary may require.

"(2)(A) The health systems agency for the health service area in which is located a hospital applying for a grant under the program shall (i) in making the review of the applicant's application under section 1513(e), determine the need for each service or part proposed to be discontinued by the applicant, (ii) in the case of an application for the conversion of a facility, determine the need for each service which will be provided as a result of the conversion, and (iii) make a recommendation to the State Agency for the State in which the applicant is located respecting approval by the Secretary of the applicant's application.

"(B) A State Agency which has received a recommendation from a health systems agency under subparagraph (A) respecting an application shall, after consideration of such recommendation, make a recommendation to the Secretary respecting the approval by the Secretary of the application. A State Agency's recommendation under this subparagraph respecting the approval of an application (i) shall be based upon (I) the need for each service or part proposed to be discontinued by the applicant, (II) in the case of an application for the conversion of a facility, the need for each service which will be provided as a result of the conversion, and (III) such other criteria as the Secretary may prescribe, and (ii) shall be accompanied by the health systems agency's recommendation made with respect to the approval of the application.

"(C) In determining, under subparagraphs (A) and (B), the need for the service (or services) or part proposed to be discontinued or converted by an applicant for a grant, a health systems agency and

State Agency shall give special consideration to the unmet needs and existing access patterns of urban or rural poverty populations.

"(*3*) (*A*) *The Secretary may not approve an application of a hospital for a grant—*

"(*i*) *if a State Agency recommended that the application not be approved, or*

"(*ii*) *if the Secretary is unable to determine that the cost of providing inpatient health services in the health service area in which the applicant is located will be less than if the inpatient health services proposed to be discontinued were not discontinued.*

"(*B*) *In considering applications of hospitals for grants the Secretary shall consider the recommendations of health systems agencies and State Agencies and shall give special consideration to applications* (*i*) *which will assist health systems agencies and State Agencies to meet the goals in their health systems plans and State health plans, or* (*ii*) *which will result in the greatest reduction in hospital costs within a health service area.*

"(*c*) (*1*) *Except as provided in paragraph* (*3*), *the Secretary may not approve an application submitted under subsection* (*b*) *unless the Secretary of Labor has certified that fair and equitable arrangements have been made to protect the interests of employees affected by the discontinuance of services against a worsening of their positions with respect to their employment, including arrangements to preserve the rights of employees under collective-bargaining agreements, continuation of collective-bargaining rights consistent with the provisions of the National Labor Relations Act, reassignment of affected employees to other jobs, retraining programs, protecting pension, health benefits, and other fringe benefits of affected employees, and arranging adequate severance pay, if necessary.*

"(*2*) *The Secretary of Labor shall by regulation prescribe guidelines for arrangements for the protection of the interests of employees affected by the discontinuance of hospital services. The Secretary of Labor shall consult with the Secretary of Health, Education, and Welfare in the promulgation of such guidelines. Such guidelines shall first be promulgated not later than the promulgation of regulations by the Secretary for the administration of the grants authorized by section 1641.*

"(*3*) *The Secretary of Labor shall review each application submitted under subsection* (*b*) *to determine if the assurances described in paragraph* (*1*) *have been provided with the application and if they are satisfactory and shall notify the Secretary respecting his determination. Such review shall be completed within—*

"(*A*) *ninety days from the date of the receipt of the application from the Secretary of Health, Education, and Welfare, or*

"(*B*) *one hundred and twenty days from such date if the Secretary of Labor has by regulation prescribed the circumstances under which the review will require at least one hundred and twenty days.*

If within the applicable period, the Secretary of Labor does not notify the Secretary of Health, Education, and Welfare respecting his determination, the Secretary of Health, Education, and Welfare shall review the application to determine if the applicant has provided the assurances described in paragraph (*1*) *and if such assurances are sat-*

isfactory. The Secretary may not approve the application unless he determines that such assurances have been provided and that they are satisfactory.

"(d) The records and audits requirements of section 705 shall apply with respect to grants made under subsection (a).

"(e) For purposes of this part, the term 'hospital' means, with respect to any fiscal year, an institution (including a distinct part of an institution participating in the programs established under title XVIII of the Social Security Act)—

"(1) which satisfies paragraphs (1) and (7) of section 1861(e) of such Act,

"(2) imposes charges or accepts payments for services provided to patients, and

"(3) the average duration of a patient's stay in which was thirty days or less in the preceding fiscal year,

but such term does not include a Federal hospital or a psychiatric hospital (as described in section 1861(f)(1) of the Social Security Act).

"GRANTS TO STATES FOR REDUCTION OF EXCESS HOSPITAL CAPACITY

"SEC. 1643. (a) For the purpose of demonstrating the effectiveness of various means for reducing excesses in resources and facilities of hospitals (referred to in this section as 'excess hospital capacity'), the Secretary may make grants to State Agencies designated under section 1521(b)(3) to assist such Agencies in—

"(1) identifying (by geographic region or by health service) excess hospital capacity,

"(2) developing programs to inform the public of the costs associated with excess hospital capacity,

"(3) developing programs to reduce excess hospital capacity in a manner which will produce the greatest savings in the cost of health care delivery,

"(4) developing means to overcome barriers to the reduction of excess hospital capacity,

"(5) in planning, evaluating, and carrying out programs to decertify health care facilities providing health services that are not appropriate, and

"(6) any other activity related to the reduction of excess hospital capacity.

"(b) Grants under subsection (a) shall be made on such terms and conditions as the Secretary may prescribe.

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 1644. To make payments under grants under sections 1642 and 1643 there are authorized to be appropriated $30,000,000 for the fiscal year ending September 30, 1980, $50,000,000 for the fiscal year ending September 30, 1981, and $75,000,000 for the fiscal year ending September 30, 1982, except that in any fiscal year not more than 10 percent of the amount appropriated under this section may be obligated for grants under section 1643.".

(b) Section 1624 is amended by striking out "For purposes of this title" and inserting in lieu thereof "Except as provided in section 1642(f), for purposes of this title".

STUDY

SEC. 302. The Secretary of Heath, Education, and Welfare shall conduct a study of the effect on the elimination of unneeded hospital services made during the two fiscal year period ending September 30, 1981, by the program authorized by part E of title XVI of the Public Health Service Act. The Secretary shall not later than January 1, 1982, report the results of the study to Congress together with his recommendations for any revisions in the program under such part E which he determines to be appropriate, including any revision in the authorizations of appropriations for grants under such program.

And the House agree to the same.

That the Senate recede from its disagreement to the amendment of the House to the title of the bill and agree to the same.

HARLEY O. STAGGERS,
HENRY A. WAXMAN,
DAVIL E. SATTERFIELD,
RICHARDSON PREYER,
JAMES T. BROYHILL,
TIM LEE CARTER,
Managers on the Part of the House.

EDWARD M. KENNEDY,
HARRISON A. WILLIAMS, JR.,
GAYLORD NELSON,
ALAN CRANSTON,
CLAIBORNE PELL,
RICHARD S. SCHWEIKER,
JACOB K. JAVITS,
ORRIN G. HATCH,
Managers on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 544) to amend titles XV and XVI of the Public Health Service Act to revise and extend the authorities and requirements under those titles for health planning and health resources development, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate recedes from its disagreement to the amendment of the House to the title of the bill.

The House amendment to the text of the bill struck out all of the Senate bill after the enacting clause and inserted a substitute text.

The Senate recedes from its disagreement to the amendment of the House with an amendment which is a substitute for the Senate bill and the House amendment. The differences between the Senate bill, the House amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

Title I—Revision of Health Planning Authority

REVISION AND REPORTING ON NATIONAL GUIDELINES FOR HEALTH PLANNING

Reporting on Health Planning

The House amendment contains a provision, not included in the Senate bill, which requires the Secretary of the Department of HEW to review on an annual basis the goals and standards established as part of the National Guidelines for Health Planning. In carrying out this review, the plans developed at the State and areawide level should be reviewed and used as a basis for revising existing or developing new goals or standards. The Secretary is also required to collect data to determine whether the health care delivery systems are changing to meet the standards and goals included in the Guidelines and the resources required to meet the goals. The Secretary shall rely on the health systems agencies, the State health planning and development agencies and other entities to assemble and report such data. The Secretary is also required periodically to make a public statement about the goals contained in the health systems plans and the State health plans and to summarize the resources required to meet them (section 101(a) and (b)).

The conference substitute conforms to the House amendment except that the Secretary may collect data to determine whether the health care delivery systems meet or are changing to meet the goals contained in HSA and State health plans (section 101(a) and (b)).

The conferees encourage the Secretary to actively pursue the collection of data under this section so that the Federal Government may better benefit from the planning which takes place at the local and State levels.

CONSULTATION REQUIREMENTS

The House amendment contains a provision, not included in the Senate bill, which requires the Secretary to consult with various groups at least 45 days prior to initial publication or revision of the National Health Planning Guidelines (section 101(a)).

The conference substitute conforms to the House amendment (section 101(a)).

UNIQUE NEEDS OF MEDICALLY UNDERSERVED POPULATIONS

The Senate bill contains a provision, not included in the House amendment, which requires the standards promulgated as part of the National Health Planning Guidelines to reflect the unique circumstances and needs of medically underserved populations including isolated rural communities (section 101(c)).

The conference substitute conforms to the Senate bill (section 101(a)).

NATIONAL HEALTH PRIORITIES; NATIONAL COUNCIL ON HEALTH PLANNING AND DEVELOPMENT

Purpose of act

The Senate bill contains a provision, not included in the House amendment, which amends the Congressional findings established in P.L. 93–641. It states that lack of effective coordination between the mental health care system and physical health care system, their providers and planners, have promoted fragmentation, lack of continuity, and inappropriate utilization of the Nation's health care resources. It also finds that there has been a lack of attention to and emphasis on the behavioral aspects of physical health care and status (section 151).

The conference substitute conforms to the House amendment.

National health priorities

The Senate bill contains a provision which adds to the National health priorities the promotion of those health services which are provided in a manner cognizant to the emotional and psychological components of the prevention and treatment of illness and the maintenance of health (section 151).

The House amendment adds to the national health priorities the following: the discontinuance of duplicative or unneeded services and facilities, and the adoption of policies that will (a) contain rapidly rising costs of health care delivery, (b) insure more appropriate use of health care services and (c) promote greater efficiency in the health care delivery system. It also establishes priority for the development and use of cost saving technology.

The conference substitute, as a compromise, includes the priorities in the Senate bill and the House amendment (section 102(a)).

NATIONAL COUNCIL MEMBERSHIP SIZE AND REPRESENTATION

The Senate bill contains a provision, not included in the House amendment, which expands the size of the National Council of Health Planning and Development from 15 to 20 members, adds the Assistant Secretary for Rural Development of the Department of Agriculture as a non-voting ex-officio member; and provides that not less than 8 of the members shall be persons who are not providers of health services including individuals who are members of urban and rural medically underserved populations (section 101(a)).

The Conference substitute conforms to the Senate bill with a modification that the Council shall include individuals who represent urban and rural medically underserved populations (section 102(b)).

Hospital representation on the National Council

The House amendment contains a provision, not included in the Senate bill, which requires that at least one member of the Council be an administrator of a private hospital (section 102(b)).

The Conference substitute conforms to the House amendment by requiring that at least one member of the Council be a representative of a hospital (section 102 (b)).

THE ROLE OF COMPETITION IN THE ALLOCATION OF HEALTH SERVICES

Role of competition in health planning

The Senate bill amends the national priorities for health planning by adding consideration of the strengthening of competitive forces in the health services industry where competition and consumer choice can constructively serve to advance the purpose of quality assurance and cost effectiveness. It adds to the purpose of health systems agencies the preservation and improvement of competition in the health service area. Review criteria are modified by requiring consideration of less costly alternatives that are consistent with consumer preferences and that review criteria pertaining to the relationship of services reviewed to the existing health care system take into account the need to maintain and improve competitive conditions. The Senate bill also establishes additional criteria for HSA and State agency reviews pertaining to improvements or innovations in the financing and delivery of health services which foster competition and serve to promote quality assurance and cost effectiveness (section 154).

The House amendment makes Congressional findings that extensive coverage by health insurance, particularly of inpatient health services, and the prevailing methods of paying for health services through health insurance have (1) resulted in decisions being made respecting the use of health services without regard to price, (2) diminished the effect of market forces on decisions respecting the supply of health services, and (3) consequently have encouraged duplication and excess supply of health resources. For health services such as institutional health services, for which market forces do not or will not appropriately allocate supply, the house bill would require HSA's and

SHPDA's to take actions to allocate the supply of health services. For health services for which market forces appropriately allocate or will appropriately allocate supply, HSA's and SHPDA's would be required to give priority to actions which will strengthen the effect of market forces. The amendment adds to an HSA's purpose the strengthening of the effects of market forces in cases where they can appropriately allocate the supply of health services. It also amends review criteria by requiring that HSA's, SHPDA's and SHCC's consider the effect of market forces on supply and demand in their project review activities.

The conference substitute as a compromise includes findings which make it clear that for health services, such as inpatient health services and other institutional health services for which competition does not or will not appropriately allocate supply consistent with the plans of health planning agencies, the agencies should perform their functions to allocate the supply of those services where appropriate to advance the purposes of quality assurance, cost effectiveness, and access and the other purposes of title XV. For health services for which competition appropriately allocates supply consistent with the agency's plans, the HSA and State agency should in the performance of their functions give priority (where appropriate to advance the purposes of quality assurance, cost effectiveness, access and the other purposes of title XV) to actions which will strengthen the effect of competition on the supply of those services. The compromise adds to the HSA's purposes, preserving and improving, in accordance with new section 1502 (b), competition in the health service area. Two new review criteria are also established in section 1532(c). First, in accordance with new section 1502(b), the agency should consider the factors which affect the effect of competition on the supply of the health services being reviewed. Second, the planning agency should consider improvements or innovations in the financing and delivery of health services which foster competition in accordance with new section 1502(b), and serve to promote quality assurance and cost effectiveness.

DESIGNATION OF HEALTH SERVICE AREAS

Area redesignation

Existing law provides that the Secretary shall review on a continuing basis and at the request of any Governor or designated health systems agency the appropriateness of the boundaries of established health service area, and if he determines that the boundary for a health service area no longer meets the requirements for area designation, he may revise the boundary.

The requirements provide that:

1. The area shall be a geographic region appropriate for effective planning and development of health services;
2. To the extent practical, the area shall include at least one center for the provision of highly specialized health services;
3. The area shall have a population of not less than 500,000 or more than 3,000,000 except in certain circumstances;
4. To the maximum extent feasible, the boundaries of the area shall be appropriately coordinated with the boundaries of profes-

sional standards review organizations, existing regional planning areas and State planning and administrative areas;

5. The boundaries shall be established so that the economic or geographic barriers to receive those services in nonmetropolitan areas are taken into account;

6. Boundaries shall be established to recognize differences in health planning and health services development needs between metropolitan and nonmetropolitan areas; and

7. Each standard metropolitan statistical area shall be entirely within the boundaries of one health service area, except that if the Governor of each State in which the standard metropolitan statistical area is located determines, with the approval of the Secretary, that in order to meet the other requirements of the subsection, the health service area should contain only a part of the standard metropolitan statistical area.

The Senate bill directs the Secretary to review on his own initiative or at the request of any Governor or health system agency (HSA), the boundaries of a health service area and to redesignate those boundaries if he finds that they no longer meet the requirements of section 1511(a) or if the boundaries for the revised health service area meet the requirements of section 1511(a) in a significantly more appropriate manner in terms of the efficiency and effectiveness of health planning efforts. This bill also amends the various consultation requirements required prior to an area redesignation and requires the Secretary by January 1, 1980 to establish by regulation criteria for the revision of health service area boundaries (section 102).

The House amendment provides that the Secretary may redesignate areas if the Secretary determines the area no longer is the geographic region appropriate for effective planning and development of health services and that the proposed revision of the boundaries of the health services area would establish a region appropriate for effective planning and development and would meet at least one other of the area designation requirements (section 104(a)).

The conference substitute conforms to the Senate amendment, however, area redesignation criteria would have to be published within one year of enactment (section 104(a)).

The conferees wish to emphasize that a health service area boundary should be altered only when absolutely necessary and only after the Secretary balances the cost of redesignation (in terms of disruption to the health planning process, nonproductive changes in the governing body membership or erosion of local support for health planning) against any potential benefits from such redesignation. The conferees expect that area redesignation will occur only in those circumstances where there is no doubt that positive benefit will accrue for health planning in the area.

Entities eligible under section 1536

The House amendment contains a provision, not included in the Senate bill, which adds the Commonwealth of Puerto Rico to the States and territories that fall under the provisions of section 1536. That section that no health service area or health systems agency be established and permits the State agency to perform the function of the HSA (section 104(c)).

The conference substitute conforms to the House amendment (section 104(c)).

Area designation for interstate standard metropolitan statistical areas

The Senate bill contains a provision, not included in the House amendment, which would change existing law to permit the Governor of a State, which contains a health service area including part of an interstate standard metropolitan statistical area to recommend that the area be broken up in order to meet the other designation criteria (section 101(b)). Existing law requires that the Governor of each State in which a standard metropolitan statistical area is located determine that a split is necessary.

The conference substitute conforms to the House amendment. The conferees note that one of the most important criteria for the designation of health service areas is that a standard metropolitan statistical area not be divided. In any redesignation of health service areas the conferees expect the Secretary to give considerable weight to this criteria.

DESIGNATION OF HEALTH SYSTEMS AGENCIES

Governor and SHCC involvement in agency designations

The Senate bill provides that in considering applications for HSA designations, the Secretary shall give priority to any application which has been recommended by a Governor or a SHCC for approval (section 127 (d) and (e)).

The House amendment provides that the Secretary shall give priority to any application which has been recommended for the approval by the Governor (section 105).

The conference substitute conforms to the Senate bill (section 105(a) and (b)).

Consultation with national council on agency termination

The House amendment contains a provision, not included in the Senate bill, which requires the Secretary to consult with the National Council on Health Planning and Development prior to terminating or failing to renew an HSA or State agency designation (section 105(d) and section 122(g)).

The conference substitute conforms to the House amendment (section 105(d), section 123(b)).

Assistance to entities desiring to become HSA's

The Senate bill contains a provision, not included in the House amendment, which requires the Secretary to provide technical assistance to entities desiring to become HSA's (section 125).

The conference substitute conforms to the Senate bill (section 105(f)).

Limits on designated agencies

The Senate bill would allow the Secretary to return an HSA to conditional designation status for one year if the agency's operation and performance of its functions has not been fulfilled in a satisfactory manner (section 127).

The House amendment provides that if the Secretary determines that an HSA does not continue to meet requirements of the Act, the Secretary may renew a designation agreement for such agencies under such conditions as the Secretary determines appropriate (section 105).

The conference substitute conforms to the Senate bill (section 105(h)).

Periodic review of performance

The Senate bill contains a provision, not included in the House amendment, which provides that the Secretary shall consider the comments submitted by any interested person when making reviews of the performance of health systems agencies and State agencies (section 150).

The conference substitute conforms to the House amendment.

PLANNING GRANTS

Minimum grants

The Senate bill increases the minimum grant which an HSA must receive to a level of $250,000 for fiscal year 1980; $270,000 for fiscal year 1981; and $290,000 in any succeeding fiscal year (section 129).

The House amendment provides that an HSA may not receive less than $200,000 for fiscal year 1980; $215,000 for fiscal year 1981; and $230,000 in any succeeding year (section 106).

The conference substitute as a compromise specifies than an HSA may not receive less than $225,000 in fiscal year 1980; $245,000 in fiscal year 1981; and $265,000 in each succeeding year (section 106).

Funding formula

The House amendment contains a provision, not included in the Senate bill, which modifies the existing HSA formula to provide that an HSA receive $.70 per capita for its first million population, $.50 per capita for its second million population or part thereof, and $.30 per capita for any population over two million. However, if the Secretary determines that the amount provided by the formula is not needed by the agency, the amount of the grant may be reduced (section 106(a)).

The conference substitute as a compromise specifies that an HSA should receive an amount equal to $.60 per capita.

If the formula yields an amount which is not needed by the Agency to adequately perform its functions, the amount of the grant may be reduced by the Secretary following a hearing (section 106).

Extraordinary expenses

The Senate bill allows the Secretary to increase the funding levels of health systems agencies to recognize any extraordinary expenses including, but not limited to, expenses resulting from the agency's health service area being located in more than one State, from the agency serving a large urban and rural medically underserved population or a large health service area and expenses due to the development of innovative planning techniques. Up to 5% of the total amount appropriated could be used for this purpose (section 129).

The House amendment provides that the Secretary may use up to 5 percent of the amount appropriated to assist an agency in meeting extraordinary expenses including extraordinary expenses resulting

from the agency's health service area being located in more than one State or from the agency's serving a large health service area (section 106(b)).

The conference substitute conforms to the Senate bill (section 106(b)).

In authorizing this discretionary funding of HSA's to meet certain extraordinary expenses, conferees are cognizant that immediate or full implementation of this authority could result in some HSA's initially receiving less funds in fiscal year 1980 than they had in fiscal year 1979. Full implementation of this authority should be dependent on the availability of additional HSA funding in fiscal year 1980 which would not necessitate reductions in the per capita funding of HSA's.

MEMBERSHIP REQUIREMENTS

Labor organizations

The Senate bill clarifies provisions of existing law that major purchasers of health care include, but are not limited to, unions and corporations (section 110).

The House amendment clarifies that the requirement to include major purchasers of health care on an HSA governing body includes labor organizations (section 108(d)).

The conference substitute conforms to the Senate bill (section 108(d)).

Representation of medical schools

The House amendment contains a provision, not included in the Senate bill, which adds to the categories of providers in section 1512 (b)(c)(ii) (1) the dean of at least one school of medicine in the area (section 108(a)(2)).

The conference substitute conforms to the Senate bill (section 108(a)(2)).

Mental health representation

The Senate bill strikes out health care in each place that it occurs and inserts in lieu thereof health or mental health care in both sections 1512(b)(3)(c) and 1531(3) (section 113(b)).

The House amendment modifies the HSA governing board membership to include (through consumer and provider members) individuals who are knowledgeable about mental health services (including services for substance abuse) (section 108).

The conference substitute as a compromise includes the House provision and establishes a reference to health which includes physical and mental health (section 126).

In changing the law with respect to mental health representation, the conferees expect each health systems agency to solicit the active involvement on their governing board and committees of persons knowledgeable about mental health services, including services for alcohol and drug abuse. This is particularly important given other changes in the bill which emphasize that mental health goals are to be included within the health systems plan. Because of the importance of mental health, drug abuse, and alcoholism issues, the conferees feel that it is important that at least one provider and one consumer member of the HSA board be knowledgeable about these services.

Medicine and osteopathy

The Senate bill contains a provision, not included in the House amendment, which clarifies that the term physician includes both doctors of medicine and osteopathy (section 112).

The conference substitute conforms to the House amendment although a definition of physician is added to the law (section 126).

Nonprofessional health worker

The Senate bill contains a provision, not included in the House amendment, which broadens requirements pertaining to an HSA governing body by adding non-professional health workers to the provider categories (section 113).

The conference substitute conforms to the House amendment.

Alcohol and drug abuse

The Senate bill contains a provision, not included in the House amendment, which strikes the word "substance" and inserts in lieu thereof "alcohol and drug" in section 1512(b)(3) and section 1531 (section 113).

The conference substitute conforms to the Senate bill (section 108).

Direct providers

The House amendment contains a provision, not included in the Senate bill, which requires that at least one half of the providers shall be direct providers and at least one of them shall be engaged in the administration of hospitals (108(a)(3)).

The conference substitute conforms to the House amendment (section 108).

Broadly represented HSA Board

The House amendment contains a provision, not included in the Senate bill, that modifies existing law by requiring that the consumer members of an HSA governing body be broadly representative of the health service area and include individuals representing the principal social, economic, linguistic, handicapped, and racial populations in geographic areas of the health service area and major purchasers of health care (section 108(a)).

The Conference substitute conforms to the House amendment (section 108(a)). The conferees emphasize that, the consumer members are to be "broadly representative" of the health service area. Several different approaches in insuring meaningful involvement in HSA decisions by all segments of society are permissible. However, it was not the intent of the Congress in enacting this provision to mandate a quota system requiring the selection of representatives of a particular category strictly proportionate to its representation in the population of the area or to require that representatives of a category be members of the class they represent. Instead, the Congress intended, in implementation of this requirement, that health systems agencies have the flexibility to adopt selection processes most appropriate to local needs.

The conferees note that there has been some confusion about the qualifications necessary to be a representative of a specific population. Such qualifications would include membership in the population group, or selection by members of the group.

The Congress received considerable evidence, which indicated that the broadly representative requirement for the consumer members of HSA governing bodies is not being met particularly with regard to low and moderate income persons. The conferees expect that HEW will now move rapidly to issue regulations concerning this and other governing body requirements in this legislation.

Local elected official participation

The Senate bill requires that HSA's must include public elected officials and other representatives of units of general purpose local government on their governing bodies. In the latter case individuals would have to be appointed by a unit of general purpose government or a combination thereof. In a case of a single State health service area, the State government of the State would be deemed a unit of general purpose local government for the purposes of this provision (section 107(b)).

The House amendment clarifies the requirement that public elected officials and other representatives of general purpose local government are required to be included in the membership of the health systems agency governing body (section 108(b)).

The conference substitute conforms to the Senate bill (section 108 (b)).

Definition of provider of health care

The Senate bill modifies the definition of provider of health care by providing that an individual shall not be considered an indirect provider of health care solely because he is a member of a governing body of an entity engaged in the provision of health care or in research or in instruction or engaged in producing drugs or other articles. The Senate bill also strikes the word "substance" and inserts in lieu thereof "alcohol and drug" (section 141).

The House amendment revises the definition of provider of health care by deleting the notion of indirect provider. Deleted from the existing definition of provider are the following: (1) board members of voluntary health organizations who do not have as their primary purpose the delivery of health care, the conduct of research or the conduct of health professional instruction; and (2) the immediate family of a provider with the exception of the provider's spouse. The income test for a provider is changed from one-tenth to one-third (section 108).

The substitute as a compromise includes the Senate and House provisions with the exception of the deletion of the immediate family of a provider from the definition of a provider, and a change in the income test for a provider from one-tenth to one-fifth (section 108(d)).

Waiting period for providers

The Senate bill contains a provision to remove the stipulation that consumers on HSA boards cannot have been providers of health care within the 12 months preceding the appointment (section 110).

The House amendment includes a similar provision although it applies only to indirect providers (section 108(d)).

The conference substitute conforms to the Senate bill (section 108(d)).

Veterans' Administration participation

The Senate bill clarifies that "ex officio" means non-voting when referring to the ex officio members of a health systems agency governing body (section 114(b)).

The House amendment provides that the representative of the Veterans' Administration shall not be included in determining the numerical limits of an HSA, i.e., an HSA required to have a VA representative can have a 31 member governing body (section 108(b)(3)).

The conference substitute as a compromise contains both the provisions of the Senate bill and the House amendment (section 108(b)(3)).

Consumer majority on committees

The Senate bill provides that a majority of the members of any HSA subcommittee or group must be consumers of health or mental health care (section 115). It also deletes the requirement that all committees meet the other representational requirements and deletes the phrase "of its members".

The House amendment provides that appointments will be made to HSA subcommittees and groups in such a matter that a majority of their members shall be consumers of health care (section 108(e)).

The conference substitute as a compromise conforms to the House amendment and includes the Senate provision which makes it clear that other than governing body members can serve on the HSA's committees (section 108(e)).

GOVERNING BODY SELECTION

The Senate bill sets forth guidelines for the process to be used by the HSA in selecting members of its governing body and subarea councils. That selection process should assure that members are selected in accordance with the compositional requirements of the Act, that there is opportunity for broad participation by the residents of the health service area, that such participation will be encouraged and facilitated, and that HSA governing body members do not select other members of the governing body. The selection process is to be made public and reported to the Secretary (section 106).

The House amendment contains a similiar provision except that any required change in the selection process would have to be made only to the extent permitted by the State law applicable to the incorporation of the agency and the existing members would not be prohibited from selecting new members of the governing body (section 109).

The conference substitute requires that one-half of the members of the governing body be selected by other than the existing members of the governing body. It also provides that, if the subarea council is authorized to select or selects one or more members of the governing body of the health systems agency, then one-half of the members of the subarea council must be selected by other than the existing members of the subarea council (section 109).

The conferees express particular concern about testimony concerning the process through which consumer and provider representatives are selected to HSA governing bodies. The present law allows an HSA

governing body to be self-selected. The conferees are concerned as a result these agencies, which are supposed to be open and accessible can become closed with a self-perpetuating board providing policy direction unsupported by the general public. The conferees view such a prospect with concern and have thus adopted this provision which will prohibit self-perpetuation.

RESPONSIBILITIES OF GOVERNING BODIES

Public HSA responsibilities

The Senate bill provides that an HSA that is a public regional planning body or a unit of local government shall not be required to delegate to the separate governing body for health planning the exclusive authority to appoint and with cause remove members of the governing body for health planning, establish personnel rules and practices for staff or approve the agency's budget or any combination of these activities (section 107(a)).

The House amendment provides that when a health systems agency is a public regional planning body or a unit of local government, the public board shall be responsible for the establishment of personnel rules and practices for the staff of the agency and for the agency's budget unless the governing body for health planning is specifically authorized to perform these functions. It also provides for the public board to appoint the members of the separate governing body for health planning. The House amendment in addition specifies that when an HSA elects to have a governing body of more than 30 members and establishes an executive committee that has authority to take action for the board, then the executive committee shall be composed of not less than 10 members, or more than 30 members. Existing law limits the committee to 25 members (section 110(a) and (b)).

The conference substitute conforms to the House amendment (section 110(a) and (b)).

Liability

The Senate bill amends existing law to revise and broaden the scope of protection against personal liability for money damages and to provide protection for consultants and agents of the HSA, as well as members and employees. The bill provides that no such individual will be considered liable if the individual believed he or she was acting within the scope of official duties and acted without gross negligence or malice toward any person affected by it. The Senate bill also extends the same protection against personal liability suits to SHCC members, employees, consultants, and agents (section 116).

The House amendment clarifies the immunity from liability for money damages for HSA board members and employees and extends the immunity to the HSA. An exception to this immunity is established for civil actions for bodily injury to individuals or physical damage to property (section 110(d)).

The conference substitute includes both the Senate bill and the House amendment although the Senate provision extending immunity to consultant or agents for HSAs or SHCCs is not included (section 110(d)).

Plan development in a public HSA

The House amendment contains a provision, not included in the Senate bill that provides that in the case of a health systems agency such as a public regional planning body or a unit of general local government, the planning body or unit of government shall only be given a reasonable opportunity to comment on the health systems plan and annual implementation plan proposed by the governing body and to propose additions to and other revisions in it. It further provides that any such proposed additions or revisions not included in the plan by the agency shall be appended to the plan. This provision would not affect the authority over the plan of the four existing HSA's which are units of local government (section 115(g)).

The conference substitute conforms to the House amendment which would allow four existing HSA's which are units of local government (those serving Montgomery County, the City of Chicago, Santa Clara County, and the Navajo Nation) to review and approve the health systems plan and the annual implementation plan. All other public HSA's would be given a reasonable opportunity to comment on the health systems plan and annual implementation plan proposed by the separate governing body for health planning and to propose additions to and other revisions in it. The separate governing body for health planning of all public health systems agencies including the four HSAs (designated above) which are units of local government, shall have exclusive authority to perform all the other functions described in section 1513 (section 110(e)).

Prohibition against lobbying

The House amendment contains a provision which provides that none of the funds authorized under Titles XV and XVI shall be directly or indirectly used to pay for the personal services of individuals intended to influence executive orders or legislation (section 110).

The conference substitute as a compromise provides that no funds may be used by health systems agencies directly to pay any individual to influence executive orders or regulations or legislation. The prohibition however, does not apply with respect to compensation paid by a health systems agency to an employee of the agency unless the primary responsibility of the employee is to influence such governmental action (section 110(f)).

This provision was adopted to prohibit an HSA from hiring or contracting with an individual to lobby. The conferees, however, recognize that HSA staff and board members have a right to represent their agency's view before both executive and legislative branches. This amendment is not intended to in any way to alter that right.

The conferees also wish to make it clear that the substitute does not prohibit an HSA from joining a tax-exempt organization, such as the American Health Planning Association, which might lobby consistent with its tax-exempt status.

The conferees note that the purpose of this substitute is to permit the effect of the decision in *Montgomery County, Md.* v. *Califano*, 499 F. Supp. 1230 (1978) to continue only with regard to review and approval of the health systems plan and annual implementation plan by

the four existing HSA's (designated above) which are units of local government.

MEETINGS AND RECORDS

The Senate bill would amend existing law to exclude from the open meeting requirement meetings or portions of meetings called to discuss the performance or remuneration of an HSA employee which, if public, would constitute a clearly unwarranted invasion of personal privacy of such individual. The bill extends similar scope of protection to HSA and State personnel records and data including restrictions on the Secretary's access to such records and data (section 109).

The House bill amends existing law to provide that the health systems agency is not required to conduct in public those portions of business meetings that deal with information of a personal nature the disclosure of which would constitute a clearly unwarranted invasion of personal privacy or, information relating to the agency's participation in a judicial proceeding. Similar provisions would apply to the agency's data and records. The House amendment provides that the State agency is to conduct its business meetings in public and make records and data available in accordance with State law. Similar provisions to insure openness in the health planning process are added in regard to an agency's executive committee (section 111).

The conference substitute as a compromise provides that HSA's and State agencies are to hold their meetings in public, except that any part of a meeting may be closed if the governing body or State agency determines that information respecting the performance or remuneration of an employee of the agency will be disclosed and such disclosure would constitute a clearly unwarranted invasion of personal privacy of that employee, or that information relating to an agency's participation in a judicial proceeding would be disclosed. Similarly, HSA's and State agencies would be required to make available, upon request, to the public all their records and data except for personnel and medical files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy, and records or data relating to their participation in a judicial proceeding (section 111).

SUPPORT AND REIMBURSEMENT FOR MEMBERS OF GOVERNING BODIES

Support for governing body members

The House amendment contains a provision, not included in the Senate bill, which requires that each health systems agency have an identifiable program to provide assistance to the members of its governing body and committees including a means to define the support needs of the members and to provide the members with the support, training, and continuing education which is needed (section 112(a)).

The conference substitute conforms to the House amendment (section 112(a)).

Reimbursement for members of governing bodies

The Senate bill modifies existing law to allow HSA's when appropriate to make advances to HSA members for their reasonable costs incurred in attending meetings and performing other needed functions of the health systems agency (section 108).

The House amendment provides that the HSA, where appropriate, can make advances to the Board members for the reasonable costs incurred in attending meetings in the governing bodies (section 112(b)).

The conference substitute conforms to the Senate bill (section 112(b)).

Governing body staff support

The Senate bill provides that at least one member of the staff should be designated as having the responsibility to provide the consumer members of the governing body with such assistance as they may require to effectively perform their functions (section 105(c)).

The House amendment has a similar provision although the designated staff member would be responsible for providing assistance to both consumer and provider members of the governing body (section 112(c)).

The conference substitute conforms to the House amendment except that it provides that the staff assistance is particularly for the consumer members (section 112(c)).

The conferees have adopted this addition to the House amendment because consumers generally have less familiarity with health care issues and medical practices than provider members of the board and thus in many instances may require special staff assistance.

CONFLICTS OF INTEREST

The Senate bill provides that each health systems agency and Statewide health coordinating council (SHCC) shall adopt procedures to insure that no member, employee, consultant or agent participates in any matter regarding any person, institution, organization or other entity with which he or she has had in the past three years substantial direct or indirect employment, fiduciary, competitive, medical staff, or ownership or financial interest (section 104 (a) and (b)).

The House amendment provides that no member of the governing body or its subunits may vote on project reviews regarding an individual or entity with which such member has any substantial ownership, employment, fiduciary, contractual, creditor, or consultative relationship. It also requires adequate disclosure of any such conflict of interest in relationship to any matter before the HSA. Similar requirements are added for members of the Statewide health coordinating council (section 113 (a) and (b)).

The conference substitute as a compromise conforms to the House amendment with the addition of medical staff relationships and a one year period during which a member may not have had a conflict of interest (section 113).

STAFF EXPERTISE

The Senate bill requires HSA staff to have expertise in financial and economic analysis, public health and disease prevention, mental health planning and development, and the use of mental health resources. It further provides that to the extent practical HSA's must have staff meeting these and other requirements. It also clarifies that the functions of planning and of development of health resources include mental health resources (section 105 (a) and (b)).

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The House amendment adds expertise in both financial and economic analysis and the prevention of disease and other public health matters to the list of expertise which should be present, to the extent feasible, in a health systems agency staff (section 114).

The conference substitute as a compromise adds expertise in both financial and economic analysis, the prevention of disease and other public health matters to the list of expertise that must be present on the health systems agency staff. It also clarifies that expertise in health planning includes mental health planning just as references to health resources include mental health resources (section 114).

HEALTH PLAN REQUIREMENTS

Health plan format

The Senate bill provides that the SHCC shall establish (in consultation with the HSA's within the State and the State Agency) a uniform format for health systems plan and annual implementation plans. It also requires the HSA to develop its plan in accordance with the format prescribed (section 138).

The House amendment provides that the SHCC shall establish a uniform format for health systems plans and require that the HSA develop its plan in accordance with that format (section 115(a) and (b)).

The conference substitute conforms to the Senate bill (section 115(a)).

Planning agencies involvement in environmental health issues

Both the Senate bill and the House amendment contain a provision which provides that a health systems plan's goals relating to the description of a healthful environment are to be concerned "primarily with regard to health care equipment, and health services provided by health care institutions, health care facilities, and other providers of health care and health resources" (section 115(b)).

It is the intent in adding this provision to encourage health systems agencies to focus their energies on issues directly relating to health planning and resources development.

The conferees intend, however, that this provision not prevent an HSA from involving itself in improving the environment which impacts on health. In fact, the conferees expect that this bill will expand and enhance the role of disease prevention activities (particularly involvement in environmental, occupational, nutritional health programs) in the health planning and implementation process. It is expected tht HSA's and State health planning agencies will focus greater attention, personnel, and resources on identifying and correcting preventable diseases and conditions. Too little effort has been directed at disease prevention under health planning legislation in the past.

At the same time, the conferees recognize that in many areas environmental, occupational, nutritional health programs are presently in existence. In such cases, it is not the conferees intent to require duplication of effort by health planning agencies. Health planning agencies should be actively involved in identifying problems and unmet needs in existing disease prevention programs. The planning agency should identify the consequences to the health of its areas citizens and the im-

pact on rising costs of the failure to address adequately environmental health problems. It should serve as a catalyst for action to improve public health in such circumstances.

Mental health and the HSP

The Senate bill requires the health systems plan to include an identifiable alcohol abuse, drug abuse and mental health component and to address specifically the needs of all medically underserved populations in the health service area (section 119(c)).

The House amendment requires that the HSP include goals for the delivery of mental health services in its health service area which goals shall be developed under a procedure through which persons knowledgeable about such services will be consulted (section 115(b)).

The conference substitute conforms to the House amendment (section 115(b)).

The conferees expect that the goals and related resources requirements for mental health and drug abuse and alcoholism services will be integrated into the health systems plan by an HSA. While an HSA may desire to have separate sections of the plan dealing with these issues, it is not required to do so. The conferees realize that the manner in which the health goals are included in the plan will vary from agency to agency and will depend in large part on the taxonomy with which an HSA is viewing the health system and in turn developing its plan.

Statewide health needs

The House amendment contains a provision not included in the Senate bill, which requires the State health planning and development agency to determine the health needs of the State which are statewide and requires the health systems plan to be developed in a way which is responsive to those statewide health needs. In determining statewide health needs, recommendations are to be sought from the State health authority, State mental health authority and other agencies in State government and the Statewide Health Coordinating Council (section 115(c)).

The conference substitute conforms to the House amendment (section 115(c)).

Coordination of health and mental health planning

The Senate bill requires that the preliminary State health plan include an identifiable alcohol abuse, drug abuse and mental health component to be prepared by the respective alcoholism drug abuse and mental health authorities designated by the Governor.

The alcohol abuse, drug abuse and mental health components of the HSP's submitted by the HSA's for inclusion in the State Health Plan may, if found necessary by the respective State authorities, contain revisions of such components to achieve their appropriate coordination or to deal more effectively with Statewide alcohol abuse, drug abuse, and mental health needs. The remainder of such preliminary State plan, may, if found necessary by the State Agency, also contain revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with Statewide health needs. The preliminary State plan is submitted to the SHCC for approval or disapproval and for use in developing the final State health plan (section 135(b)).

The House amendment requires the State Agency to refer the HSP's to the State health authority, the State mental health authority and other agencies of State government designated by the Governor to review the goals and related resource requirements of the HSP's and to make written recommendations to the State Agency respecting such goals and requirements. If the State Agency does not take one of the actions proposed in a recommendation submitted under this procedure, the State Agency will make available to the public a written statement of its reasons for taking such action. In reviewing these portions of the State health plan, the SHCC may establish a procedure under which persons knowledgeable about mental health services will have an opportunity to make recommendations to the SHCC. The State health authority, the State mental health authority and other agencies of State government are required to carry out those parts of the State health plan which relate to State government (section 115(c)).

The conference substitute conforms to the House amendment (section 115(c)).

The Senate bill requires the coordination of the State health plan with the State mental health plan, the State alcohol abuse plan and the State drug abuse plan (section 118(d)).

The House amendment requires the plan required by section 303(a) of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 and the plan required by section 409(e) of the Drug Abuse Office and Treatment Act of 1972 to be consistent with the State health plan in effect for such State. It also makes changes in the Community Mental Health Centers Act to assure consistency between the two planning processes (section 115(j) and (k)).

The conference substitute as a compromise requires that the mental health, drug abuse and alcoholism plans be consistent with the State health plan (section 115(j)).

The conferees have adopted provisions contained in both bills which seek to integrate mental health, alcohol and drug abuse planning into the general areawide and state health planning process. The act requires that state programs must provide for consultation and coordination with the appropriate responsible state agency for these health services. Moreover, the laws governing mental health, alcohol and drug abuse activities have been amended to require that each respective state plan be consistent with the state health plan under this act.

The conferees were unable to avoid the development of dual state health plans required by existing law. However, it is expected that every effort will be made by the Secretary to eliminate overlap and duplication between the state plans and to reduce the requirements imposed by regulations on those organizations seeking Federal support in these areas. The conferees expect that efforts will be undertaken to allow the mental health, alcohol and drug abuse plans to be completely incorporated into the SHP. In the meantime it is expected that the State health plan be the policy plan for all health services in the State and that each of the categorical plans set forth programs for State health plan implementation for their respective areas of responsibility.

Health systems plan and State health plan requirements

The Senate bill sets forth specific material to be included in health plans. In addition to the other requirements, the HSP and the State health plan must include a description of the institutional health services needed for the well being of persons receiving care within the health service area, including at a minimum, the number of type and medical facilities, rehabilitation facilities, nursing homes, beds and equipment needed to provide acute inpatient, psychiatric inpatient, obstetrical inpatient, neonatal inpatient, long-term care, and treatment for alcohol and drug abuse; the extent to which existing medical facilities, rehabilitation facilities, nursing homes, beds and equipment are in need of modernization or conversion to new uses; and, the extent to which new medical facilities, rehabilitation facilities, nursing homes, beds and equipment need to be constructed or acquired. Similar information would have to be provided on other non-institutional health services including the number and type of health maintenance organizations, outpatient facilities, rehabilitation facilities, facilities for treatment of alcohol and drug abuse and other medical facilities, and home health agencies and equipment needed to provide public health services and outpatient care (section 118(a) and (d)).

The House amendment requires that the health systems plan include a statement of the resources—personnel, facilities, and other resources—which the agency determines are needed to meet the goals set forth in the health systems plan. The HSA may identify in such statement any health care facility which provides inpatient health services which should undertake such changes (section 115(b)).

The conference substitute as a compromise provides that both the health systems plan and the State health plan shall describe the institutional health services needed in the area including at a minimum, acute inpatient, rehabilitation and long-term care services and other health services needed to provide for the well being of persons receiving care within the health service area including at a minimum preventive, ambulatory, and home health services. The health systems plan shall also describe the number and type of resources, including facilities, personnel, major medical equipment, and other resources required to meet the goals of the health systems plan and shall state the extent to which existing health care facilities need modernization, conversion to other uses, or closure and the extent to which new health care facilities need to be constructed or acquired (section 115(d)).

The conferees note that in adopting this provision it is their desire that plans developed at the areawide and State level become more specific in order to improve their usefulness as a regional or state-wide guide for the development of new, or modification of existing, health care services. In doing so the planning agency is expected as appropriate to identify the health care facilities, organizations, or individuals, which should undertake the proposed changes set forth in the plan.

Health plan procedures

The Senate bill adds a public hearing requirement for the establishment, review, and amendment of the annual implementation plan as well as the HSP (section 119(b)).

The House amendment requires the annual implementation plan to include a statement of the resources needed to meet the objectives of the AIP. It also requires that the HSA assure that the public has adequate input into the development and revision of the AIP. It also provides that if an HSA is a public regional planning body or unit of general local government, the public board shall have an opportunity to review and comment on the AIP (section 115(e)).

The conference substitute combines the Senate and House approaches (section 115(e)).

The conferees note that the requirement for notification and a public hearing by an HSA regarding revisions in its AIP or HSP is intended to give interested persons an opportunity to present their views on the proposed plan or proposed changes in existing plans which are substantive in nature. It is not intended that public hearings be held for every conforming, editorial, or other minor change in an existing plan.

Plan and the national guidelines

The Senate bill deletes the requirements of existing law that the goals in the health systems plan are to be consistent with the national guidelines for health planning. The HSA shall submit to the SHPDA, SHCC and the Secretary a detailed statement of the reasons for any inconsistencies between the HSP and the AIP and the national guidelines and priorities (section 119 (d) and (e)).

The House amendment deletes the requirement in section 1513(b)(2) that the goals of the SHP are to be consistent with the national guidelines for health planning. This makes it clear that the HSA can establish goals that are different from the national guidelines in order to be responsive to the unique needs and resources in its area. It also requires that if the goals contained in the HSP are not consistent with the national guidelines, the HSA shall provide the SHPDA and the SHCC with a detailed statement for the reasons for the inconsistency (section 115(g)).

The conference substitute conforms to the House amendment with the Senate bill's reporting requirement (section 115(f)).

Governors' involvement in the State health plan

The Senate bill requires that the State health plan prepared by the SHCC have the concurrence of the Governor (section 118(c)).

The House amendment provides that the State health plan approved by the SHCC shall be the State health plan for the State unless within 60 days after its approval, the Governor disapproves the plan because it does not effectively meet the established statewide health needs. In doing so, the Governor shall make a detailed statement on the basis for his determination that the plan does not meet statewide health needs and shall specify the changes in the plan which are needed (section 115(h)).

The conference substitute as a compromise specifies that the State health plan, as approved by the SHCC, shall be the State health plan only with the approval of the Governor. The State health plan may be disapproved by the Governor only if the Governor determines that the plan does not effectively meet statewide health needs. In disapproving the plan, the Governor shall make public a detailed statement of the basis for his determination that the plan does not meet statewide

health needs and shall specify the changes in the plan which are needed (section 115(g)).

Plan as a condition of a grant

The Senate bill contains a provision, not included in the House amendment, which stipulates that until a State health plan is in effect, the Secretary may not make any grants to the State health planning and development agency pursuant to section 1525 (section 118(e)).

The conference substitute conforms to the Senate bill (section 115 (g)).

Technical assistance by HSA's

The Senate bill contains a provision, not included in the House amendment, which requires the HSA to provide technical assistance in obtaining and filling out necessary forms to applicants applying for projects to achieve the HSP (section 120).

The conference substitute conforms to the Senate bill (section 115 (h)). The conferees note that this requirement is added so that the health systems agency will include in the technical assistance it provides guidance to applicants and others in completing the agency's forms and in meeting the necessary application requirements for a certificate of need. It should be clear that the HSA is not expected to complete the forms and applications but merely to assist the applicant in meeting the application requirements.

Planning cycle

The Senate bill requires that plans be reviewed at least every three years (sections 119(a), 120(b), 136(c)).

The House amendment provides that plans be reviewed on a biennial basis (section 115(i)).

The conference substitute conforms to the Senate bill (section 115 (i)).

The conferees in accepting the Senate provision that HSA's and SHCC's be required to review the complete health systems plans every third year believe that this will reduce or eliminate paperwork and duplication of effort currently caused by annual reviews and allow more time to be spent on plan implementation. Nevertheless, it is expected that those agencies which have not fully developed their plans or those agencies whose plans do not address the full scope of covered services or institutions in their areas will continue to review and revise their plans on a more frequent basis until such time as the plans are complete. All HSA's are encouraged to update or modify their plans as necessary.

HSA's and Indian tribes and organizations

The Senate bill adds a new requirement for HSA's having an Indian tribe or intertribal Indian organization located within its health service area. The HSA is directed to carry out its functions in a manner that recognizes tribal self-determination and is to seek to enter into agreements with the tribes or organizations on matters of mutual concern as defined in the regulations of the Secretary (section 153).

The House amendment adds a new provision to clarify that the development of a health systems plan or annual implementation plan in an area that includes an area under the jurisdiction of an Indian

tribe or an Alaskan Native Village does not affect the authority of the tribe or village to establish and carry out the health plan for the Indian health programs under its jurisdiction. If a health plan for Indian health programs is developed, the HSA shall include such plan in the HSP. The House amendment also provides for the sharing of data between the HSA and Indian tribes and Alaskan Native villages (section 115(f) and section 121).

The conference substitute conforms to the Senate bill and adds a provision related to the sharing of HSA data with Indian tribes and Alaskan Native Villages (section 121(b)).

CRITERIA AND PROCEDURES FOR REVIEWS

Review of criteria and procedures

The House amendment contains a provision, not included in the Senate bill, which requires that in the conduct of reviews of plans or applications for Federal funds, the SHCC shall, to the extent appropriate, use the procedures and criteria that apply to other reviews under Title XV listed in section 1532. It also provides that in the conduct of reviews the agencies shall consider the relationship of the health services being reviewed to the applicable State health plan in addition to the relationship to the relevant HSP and AIP (section 116).

The conference substitute conforms to the House amendment (section 116(a)).

Failure to complete review

The Senate bill contains a provision which provides that the failure of a health systems agency or a State agency to complete a review within the period prescribed for the review may not be deemed by the agency to constitute a negative finding, recommendation, or decision.

The House bill provides that certificate of need review shall be completed within 90 days or such additional time on which the applicant and the agency can agree; or such additional time as prescribed in State law in cases in which a request is made to the State agency for a hearing under section 1532(b)(8) or the State batches applications; or when the applicant has been cited by the Secretary of HEW for a violation of the Civil Rights Act of 1964 (section 116(b)).

The conference substitute as a compromise requires the State agency to establish a period within which approval or disapproval of the application for a certificate of need shall be made. If a State agency fails to approve or disapprove an application within the applicable time period the applicant may bring an action in an appropriate State court to require the State agency to approve or disapprove the application (section 116(d)).

The conferees wish to point out that this provision requires each State to set a time certain for the completion of a certificate of need review. The conferees emphasize, that, while the period of review may vary according to the type of application or the relevant review procedures; it is important that the applicant know at the beginning of a review the length of such review period and have a right of action against the State agency if a decision is not made within that period of time. The conferees are particularly concerned with the practice of some States in the past in which their failure to make a decision has meant automatic disapproval of the application. The conference sub-

stitute is designed to prohibit this practice. The conferees expect each State agency to make decisions within the time period which is set forth and would expect the Secretary of HEW to carefully monitor a State's performance with regard to this requirement and take whatever actions are necessary to assure that it is met.

Judicial review

The Senate bill contains a provision, not included in the House amendment, to provide for judicial review of any final decisions rendered by a State agency in regards to a certificate of need review or appropriateness review. Any person adversely affected by such decision may within a reasonable period of time after such a decision is made and any further administrative remedies are exhausted obtain judicial review of such a decision in an appropriate State court. Upon such judicial review, the decision of the State agency shall be affirmed unless it is arbitrary or capricious or was not made in conformity with the applicable law (section 133).

The conference substitute conforms to the Senate bill except that it requires judicial review to be limited to certificate of need decisions made by a State agency, and to other reviews, where appropriate (section 116(d)).

Judicial review has not been required for appropriateness review because the Act does not authorize the use of appropriateness review to require a health care institution to terminate services or to close its facility. However, the conferees intend that, any review of the appropriateness of services which could result in a health care institution being unable to provide a service or having to close in total or in part its facility or the imposition of any other sanctions as a result of the review, shall be subject to the judicial review requirements agreed to by the conferees.

Administrative review

The House amendment contains a provision, not included in the Senate bill, that requires that each decision of the State agency not to issue a certificate of need shall upon request of the person who applied for the certificate be reviewed under an appeals mechanism which is consistent with the State law governing the practices and procedures of administrative agencies or, if there is no such law, by an entity designated by the Governor (section 117(a)).

The conference substitute conforms to the House amendment and provides that any person directly affected by such decision may request a review (section 116(d)).

Notification

The Senate bill contains a provision, not included in the House amendment. which requires timely written notification to all affected parties at the beginning of a review and requires that all persons who have asked to be placed on a mailing list maintained by the HSA or State Agency be notified of certain reviews by such agencies. It also provides for timely notification of providers of health services and other persons of certain information. It requires that public hearings be held prior to any decision made in the course of HSA or State Agency review as requested by persons directly affected by the review (section 145, 146, and 147).

The conference substitute conforms to the Senate bill (section 116(d)).

Procedures for review

The Senate bill contains a provision, not included in the House amendment, which establishes requirements for HSA and State Agency reviews of certificate of need applications and reviews of the appropriateness of existing institutional health services, and where appropriate, for other reviews. The requirements are that each participant may present evidence and arguments orally or by written submission, each participant may cross examine any other participant who makes a factual allegation relative to such review, a hearing record must be maintained, HSA and State Agency decisions must be based solely on the hearing record, and there is a prohibition on ex parte contacts with individuals voting in the review process (section 144(c)).

The conference substitute requires a formal hearing before the State Agency if requested, requires the decision to be made on the record, sets forth an administrative review mechanism, provides that any person adversely affected by a final decision of a State Agency may obtain judicial review and that there shall be no ex parte contact between the applicant and any person in the State Agency with responsibility respecting the application after the commencement of a hearing on the application (section 116(d)).

The conferees intend that a formal hearing be held if the State Agency is requested to do so. If an HSA has been delegated this hearing responsibility by the State only one formal hearing is required. If an HSA has not been delegated this hearing responsibility then, if requested, the HSA may also hold a hearing which may be either formal or informal at the HSA's discretion (section 116(d)).

Criteria for review

The Senate bill provides that in reviewing construction projects the HSA and the State Agency shall consider effect of the application on the costs and charges to the public of providing health services by other persons; that in the case of existing services the quality of care provided by such facility in the past must be considered, and that in both cases consideration must be given to the extent to which such proposed services will be accessible to all residents of the area to be served by such services (section 148).

The House amendment requires that in adopting criteria the planning agency shall consider, in the case of health services proposed to be provided, the effect of their proposed services on the clinical need of health professional training programs, the extent to which such programs will have access to those services if they are to be available in a limited number of facilities and the extent to which such services will be accessible to all residents of the area to be served by the services. It also requires that in the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities similar to those provided be considered in the review process (section 116(d)).

The conference substitute as a compromise contains provisions of both the Senate bill and the House amendment (section 116(f) and (g)).

Additional procedures

The Senate bill amends section 1532(a) to stipulate that procedures and criteria for review by HSA's and State Agencies must provide that applications be submitted in accordance with established timetables, reviews be undertaken in a timely fashion, appplications of similar types of services and facilities be considered in relation to each other no less often than twice a year, and reviews of similar types of institutional health services affecting the same service area must be considered in relationship to each other. It also provides that HSA's and State Agencies must cooperate in the development of procedures and criteria to the extent appropriate to the achievement of efficiency in their review and consistency in criteria for such reviews (section 143).

The House amendment provides that reviews may be conducted in a manner that batching of applications can occur with comparisons being made among applications. It also requires the HSA, the SHPDA and the SHCC to work together in developing criteria and procedures for review (sections 116(c) and 117(a)).

The conference substitute conforms to the Senate bill (section 116(e)).

Requests for information

The House amendment contains a provision, not contained in the Senate bill, which requires health planning agencies to develop procedures that assure that requests for information are limited to only that information which is necessary to perform reviews. It also allows an applicant to designate data which he believes should not be released to the public and to submit such data separately. If the agency proposes to release such data, it shall notify the applicant at least 30 days before the release. The House amendment would also provide that the agency's procedures assure that the general public have access to all written materials "essential" rather than "pertinent" to a review (section 116(g)).

The conference substitute requires the agencies to give the applicant 15 days to provide any data requested after a review has begun.

Review of procedures

The House amendment contains a provision, not included in the Senate bill, which requires the Secretary to annually review the regulations promulgated pursuant to section 1532 relating to procedures and criteria and to allow the health planning agencies opportunity to comment on the need for the revision of the regulations. These agencies shall be consulted at least 45 days before initial publication (section 116(f)).

The conference substitute conforms to the House amendment (section 116(h)).

CERTIFICATE OF NEED PROGRAMS

State health plan and certificate of need

The Senate bill requires that certificate of need decisions be consistent with the State health plan except in emergency circumstances that pose a threat to public health (section 118(b)).

The House amendment provides that a decision to issue a certificate of need shall not be inconsistent with the State health plan (section 117(a)).

The conference substitute conforms to the Senate bill (section 117 (a)).

Sanctions and withdrawal

The Senate bill contains provisions, not included in the House amendment, which require a certificate of need program to be consistent with standards established by the Secretary. It also provides that such a program shall provide for procedures and penalties to enforce the provisions of the program and that after a certificate of need is issued a periodic review (at least every 24 months) shall be conducted of the progress being made in making the service or facility for which the certificate was issued available for use. The program shall provide for withdrawal of the certificate if there has not been substantial progress (section 136).

The House amendment provides that after a certificate of need is issued an annual review shall be conducted of the progress being made and if adequate progress is not being made, the certificate shall be withdrawn (section 117(a)).

The conference substitute combines the two provisions (section 117 (a) and (b)).

General provisions

The House amendment contains an amendment not included in the Senate bill, which clarifies and expands required certificate of need coverage with respect to major medical equipment, institutional health services and capital expenditures. It requires that States shall specify in the certificate the maximum amount of capital expenditures which may be obligated. It requires the Secretary to prescribe the extent to which a project authorized by a certificate of need shall be subject to further review if the amount of capital expenditure exceeds the maximum specified (section 117(a) and (b)).

The conference substitute conforms to the House amendment (section 117(a)).

Required approval of certain applications

The House amendment contains a provision not included in the Senate bill that requires the approval of an application for a certificate of need for a capital expenditure which is required to eliminate or prevent eminent safety hazards, to comply with State licensure standards, or to comply with accreditation standards, but only to the extent that the capital expenditure is required to eliminate or prevent such hazards or to comply with such standards (section 117(a)).

The conference substitute, as a compromise, includes the House amendment with the added requirement that approval is not required if the State agency finds that the facility or service with respect to which such capital expenditure is proposed to be made is not needed or that the obligation of the capital expenditure is not consistent with the State health plan in effect under section 1524 (section 117(a)).

Congress recognizes that some health facilities whose continued operation is absolutely necessary and is consistent with the SHP may

be required, because of licensing problems, to apply for a certificate of need for the limited purposes of coming into compliance with life safety code requirements or accreditation standards.

Congress hopes to limit the necessity for planning agencies to go through a highly formalized and time-consuming review over those projects which are clearly needed. Yet Congress is also fully aware of the burdensome costs created by excess capacity and does not intend that this provision be used to fund capital projects in facilities which are unneeded or determine by the State Agency to have excess capacity.

Limitations on criteria or conditions under a certificate of need program

The House amendment contains a provision, not included in the Senate bill, which requires that the issuance of a certificate of need may not be made subject to any criterion or condition unless the criterion or condition directly relates to (a) the ability of the applicant to provide the service for which the certificate is to be issued (b) the quality of the service and (c) the availability and accessibility of the service to patients in need of it or is otherwise directly related to a determination of the need for such service (section 117(a)).

The conference substitute as a compromise provides that the review of an application for a certificate of need shall not be made subject to any criterion and the issuance of a certificate of need may not be made subject to any condition unless the criterion or condition is directly related to the criteria prescribed by section 1532(c), the criteria prescribed by regulation promulgated under section 1532(a) before the date of enactment of this Act (see 42 C.F.R. § 123. 409–11), or criteria prescribed by regulation by the State agency in accordance with an authorization prescribed by State law. This compromise reflects the agreement of the conferees that certificate of need approval should not be subject to conditions or criteria which are not based upon Federal or State law. Furthermore, the certificate of need program may not be required to include any criterion in addition to criteria described or set forth pursuant to section 1532 (section 117 (a)). This provision prohibits the Secretary from withholding approval of a State certificate of need program under section 1523(a) (4)(B) until or unless the State adopts criteria or authorizes the imposition of conditions other than those referenced by this provision.

In order to avoid semantic arguments, the conferees wish to make clear that in this section, the term criteria means a standard or rule which may be applied to certificate of need applicants during the review process; the term condition means a required action applied to a specific applicant and established as part of a certificate of need decision following review. These general definitions would apply regardless of what term is used in State law or regulation which describes these concepts.

Coverage of major medical equipment outside a health care facility

The Senate bill requires a State certificate of need program to provide for review and determination of need prior to the acquisition of diagnostic and therapeutic equipment which will not be owned by or located in a health care facility if notice is not filed as required or the State agency finds that the equipment will be used to provide services

on a regular basis for inpatients of a hospital. Before any person enters into a contractual agreement to acquire diagnostic or therapeutic equipment that will not be owned by or located in a health care facility such person must notify the State agency of the State in which such equipment will be located of such person's intent to acquire such equipment. Such notice must be made in writing at least 30 days before the contractual arrangements are entered into to acquire the equipment with respect to which notice is given. Diagnostic or therapeutic equipment is added to the definition of institutional health service (section 136 and section 142).

The House amendment excludes from required certificate of need coverage the acquisition of major medical equipment that is not owned or located in the health care facility unless the equipment will be used to provide services for inpatients of a hospital. Any person who plans to acquire major medical equipment shall notify the SHPDA of such intent so that the agency can determine if the acquisition requires review. Major medical equipment is defined as any equipment in excess of the capital expenditure minimum, except that the term does not include medical equipment acquired by or on behalf of independent clinicial laboratories to provide clinical laboratory services.

The conference substitute conforms to the House amendment by providing that all States must require a certificate of need under their certificate of need programs for the acquisition of major medical equipment that is not owned by or located in a health care facility if that equipment is to be used to provide services for inpatients of a hospital. However, as a compromise, the conference substitute allows the States to require a certificate of need for any other uses of major medical equipment not owned by or located in a health care facility if they currently provide for the additional requirements or if they provide for such additional requirements prior to September 30, 1982. After that date, a State would be prohibited from changing its certificate of need program to include requirements that are in addition to the minimum requirements set forth in title XV (section 117(a)).

The conferees note that in order for a certificate of need program to be acceptable under title XV, it must provide for the review and approval of the acquisition of major medical equipment that will be used to provide services to patients who are inpatients of a hospital at the time the service was provided. Equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services is not required to be reviewed. The conferees want to make clear that this provision is a minimum requirement of an acceptable certificate of need program, and that a State is permitted to cover medical equipment acquired for use in other than inpatient settings, which costs less than $150,000 or which is acquired by a clinical laboratory. Although States would be prohibited from changing their law to go beyond the minimum requirement after September 30, 1982, no State which had imposed additional requirements before that date would be required to alter those requirements.

The conferees also wish to make clear that the term "contractual arrangement" is not intended to prohibit normal marketing negotiations for purchase of equipment such as a notice of intent to purchase. However, such a notice of intent to purchase would have to contain a condition to the effect that the notice of intent would only become a con-

tractual arrangement thirty days after the filing of the purchaser's required notice to the State Agency of intent to acquire such equipment.

Coverage of health maintenance organizations

The Senate bill establishes special criteria under which certificate of need applications of health maintenance organizations will be reviewed and approved. Applications of Federally qualified HMO's for new institutional health services must be approved by the State agency if it finds that (1) approval is required to meet the needs of present HMO members and new members who can reasonably be expected to enroll, and (2) that the HMO is unable to provide, through services or facilities which can reasonably be expected to be available to the organization, its institutional health services in a reasonable and cost effective manner consistent with the basic method of operation of the HMO and which makes such services available on a long term basis through physicians and other health professionals associated with the HMO. It further provides that no certificate of need program shall have provisions for the review and determination of need of the services, facilities, equipment and organization of health maintenance organizations and the entities through which their services are provided except for new institutional health services of hospitals controlled directly or indirectly by health maintenance organizations and diagnostic and therapeutic equipment of health maintenance organizations (section 148 and section 136).

The House amendment requires a State to exempt from its certificate of need program the development of new institutional health services, the acquisition of major medical equipment and the obligation of capital expenditures of (1) a health maintenance organization, (2) any other provider of health care which provides ambulatory and inpatient health services on a prepaid basis if at least 75 percent of the patients who use the service or equipment which is exempt are enrollees of the organization or provider and (3) any other provider who has entered into agreements to serve enrollees of an HMO or other providers (described in 2 above) if at least 75 percent of the annual revenues from the service, equipment, or expenditure are derived from such agreements.

If in any year an exempt HMO or provider fails to meet the 75 percent patient or revenue requirement, the State shall prohibit the HMO or provider from using the service, equipment or expenditure to provide services to individuals other than those enrolled on a prepaid basis with the HMO or provider. Notice shall be provided to the Secretary and the State Medicaid agency that the provider is prohibited from using the service, equipment or expenditure to provide services to individuals who are entitled to benefits under Titles XVIII and XIX of the Social Security Act unless the individuals are enrolled on a prepaid basis with an HMO or other exempt provider. The House amendment also provides that the certificate of need program may apply to an HMO only to the extent that it is not exempt and then only to the acquisition of major medical equipment, the offering of new institutional health services, and the obligation of capital expenditures as required in Title XV (section 117(a)).

The conference substitute, as a compromise, provides that a certificate of need program may not require a certificate of need for the

offering of an inpatient institutional health service, the acquisition of major medical equipment, or the obligation of a capital expenditure for the provision of an inpatient institutional health service by: (1) a health maintenance organization or combination of health maintenance organizations; (2) a health care facility which primarily provides inpatient services and is controlled directly or indirectly by a health maintenance organization or a combination of health maintenance organizations; or (3) a health care facility or portion thereof which an HMO or combination of HMOs has leased for a period of at least 15 years at the time of approval of the application.

To be eligible for an exemption under this provision, health maintenance organizations must meet the definition of a health maintenance organization set forth in this bill and must have an enrollment of at least 50,000 individuals singly or in combination, the facility in which the service will be provided must be geographically located so that the service will be reasonably accessible to such enrolled individuals, and at least 75 percent of the patients who can reasonably be expected to receive the institutional health services to be exempted will be individuals enrolled with such organization or organizations in combination. The applicant must submit to the State agency an application which allows the State agency to determine if the organization, combination, or facility meets the necessary requirements.

A health care facility (or any portion thereof) or medical equipment owned or controlled by an HMO or combination of HMOs with respect to which an exemption was granted under this provision may not be sold or leased or a controlling interest in such facility or equipment may not be acquired; and a health care facility (or any portion thereof) or medical equipment leased by an HMO or combination of HMOs with respect to which an exemption was granted under this provision may not be used by anyone other than the lessee HMO or combination of HMOs, unless the State agency issues a certificate of need approving the sale, lease, acquisition or use or the State agency determines (upon application) that the entity to which the facility is proposed to be sold or leased or which intends to acquire controlling interest is a health maintenance organization or combination of organizations which meet the requirements of the section. The substitute also requires the Comptroller General to conduct an evaluation of the exemption authority established under this Act.

The substitute also provides that a State may apply its certificate of need requirements to the institutional health services, major medical equipment, and capital expenditures of a health maintenance organization or of a health care facility which is controlled, directly or indirectly, by an HMO only to the extent that the organization or facility is not exempt under this provision, and then only to the offering of inpatient institutional health services, the acquisition of major medical equipment, and the obligation of capital expenditures as required under title XV. The substitute also contains a special provision for review of applications for certificates of need for non-exempt HMO's or for facilities controlled, directly or indirectly, by an HMO. Such applications shall be approved by the State agency if the State agency finds that an approval of the application is required to meet the needs of the members of the HMO and that the HMO is unable to provide its services through services and facilities which can reasonably be expected to be available to the organization in the community.

For purposes of this section indirect control of a health care facility could include such situations in which a majority of the members of the board of the hospital corporation are employees, officers or directors of an HMO or in which members of the board of an HMO are the same as the members of the board of the hospital corporation.

The conferees have allowed a "combination of health maintenance organizations" to meet the 50,000-enrollee minimum in order to permit two or more HMO's to join together to own, or control a corporation or other entity which owns, or lease a health care facility.

In permitting an exemption for an institutional health service which is owned, controlled, or leased by a combination of HMO's, the conferees intend that each of the HMO's in the combination will use the institutional health service.

Definition of capital expenditure

The House amendment contains a provision, not included in the Senate bill, which defines the term capital expenditure for purposes of a certificate of need program. A capital expenditure is defined as an expenditure made by or on behalf of a health care facility and which under generally accepted accounting principles is not chargeable as an expense of operations and maintenance or is made by a lease or comparable arrangement and which (1) exceeds the expenditure minimum, (2) substantially changes the bed capacity of the facility with respect to which the expenditures made, or (3) substantially changes the services of the facility (section 117(a)).

The conference substitute conforms to the House amendment with the exception of the provision relating to the exclusion from the definition of capital expenditure the acquisition of existing health care facilities (section 117(b)). The substitute provides that a certificate of need shall be required for the obligation of a capital expenditure to acquire (by purchase or under lease or comparable arrangement) an existing health care facility if (1) notice is not provided to the State agency before a contractual arrangement is entered into, or (2) if the State agency finds within 30 days after the date it receives such notice that the services or bed capacity of the facility will be changed in being acquired (section 117(a)). The conferees note that while this provision sets forth conditions under which a certificate of need will be required, it does not preclude a State from adopting broader coverage requirements or requiring that all acquisitions be reviewed under normal certificate of need procedures.

Definition of expenditure minimum

The House amendment contains a provision, not included in the Senate bill, which establishes a definition for the term expenditure minimum to mean $150,000 for the first 12 month period after enactment and for each 12 month period thereafter $150,000 adjusted to reflect changes in the composite construction cost index maintained by the Department of Commerce (section 117(b)).

The conference substitute would allow a State to increase the capital expenditure and annual operating cost thresholds of their certificate of need programs to reflect the change in the preceding twelve-month period of an index maintained or developed by the Department of Commerce and designated by the Secretary of HEW for purposes of making such adjustment (section 117(f)).

Osteopathic considerations

The Senate bill contains a provision that adds to the criteria required for HSA and State agency consideration the special needs and circumstances of osteopathic facilities accredited for post graduate training (section 148).

The House amendment provides that in reviewing an application for a certificate of need the HSA and State agency shall consider the application on the basis of the need for and the availability in the community of services and facilities for osteopathic and allopathic physicians and their patients. State agencies shall also consider the impact of the approval of application on training programs for doctors of osteopathy and medicine.

The conference substitute conforms to the House amendment (section 117(a)).

APPROPRIATENESS REVIEW

Minimum issues for appropriateness review

The Senate bill contains a provision, not included in the House amendment, which requires that in carrying out appropriateness reveiws, HSA's shall at a minimum address issues of need, accessibility, financial viability, cost effectiveness, costs and charges to the public and quality of service provided (section 123(a)).

The conference substitute as a compromise specifies that both HSA's and SHPDA's, in carrying out appropriateness reviews, shall at a minimum address issues of need, accessibility, financial viability, cost effectiveness, and quality of services provided (section 118(b)).

The conferees note that appropriateness review findings can be made on either an areawide basis or institution-specific basis. The decision on how specific to make an appropriateness review recommendation or finding by the health systems agency or the State agency should be based upon the nature and the seriousness of the problem which makes the service inappropriate, its susceptibility to change, the amount of information the agency has about the problem, and judgments about how best to achieve needed changes within the agency's area. It is the conferees' intent that agencies within each State make the decision on how best to handle this issue. It is the conferees' expectation that over time agencies will be able to make detailed appropriateness review findings. Such findings should provide the consumer with better information about the health services which are available so that informed choices can be made about the institutions from which services are received. Such specific findings should also provide institutions with recommendations of the changes which should take place to make the services of the area appropriate. When an agency makes its recommendation or finding on an institution-specific basis, the committee expects that it will establish hearing procedures to ensure that each institution under review will have an adequate opportunity to present all relevant information regarding its services and facilities.

REVIEW AND APPROVAL OF PROPOSED USES OF FEDERAL FUNDS

Review of project and allotment grants

The House amendment contains a provision, not included in the Senate bill, that requires the SHCC to review any application sub-

mitted to the Secretary by a State for a grant or contract awarded under the Public Health Service Act, the Comprehensive Alcohol Abuse and Alcohol Prevention, Treatment and Rehabilitation Act, or section 409, of the Drug Abuse Office and Treatment Act for projects in more than one health service area. If the SHCC recommends disapproval, the Secretary may not make Federal funds available if he finds that the application is not in conformity with the State health plan. The amendment also provides that when a State is making grants or contracts in a health service area from funds received under the covered acts, the Governor of the State shall allow the health systems agency 60 days to review the proposed use of those funds in its area and approve or disapprove such use. The Governor, after taking into consideration the HSA's decision and any comments which the SHPDA has developed, may make such Federal funds available for use notwithstanding the disapproval of the HSA only if the decision of the Governor is made available to the appropriate HSA and SHPDA and contains a detailed statement of the reasons for the decision (section 119).

The conference substitute conforms to the House amendment (section 119(a)).

Review of research and training proposals

The Senate bill provides that grants or contracts under Titles IV, VII, or VIII of the Public Health Service Act should not be reviewed by the HSA unless they are made, entered into, or used to support the development of health resources, or the delivery of health services that would make a significant change in the health services offered within the health service area (section 123(b)).

The House amendment provides that research and training under the Public Health Service Act should not be reviewed unless the grants are to be made, entered into, or used for the development, expansion or support of health resources which, in the case of grants or contracts for training, would make a significant change in the health services available in the health service area, or which, in the case of grants or contracts for research, would change the delivery of health services, or the distribution or extent of health resources available to persons in the health service area other than those who are participants in such research (section 119(b)).

The substitute conforms to the House amendment (section 119(b)). The conferees note that research includes clinical trials. Such trials include demonstration projects designed to answer questions about the general applicability of procedures, drugs, or devices with potential usefulness that have not been tested in nonlaboratory settings. The conferees intend that such projects shall not be reviewed unless the projects are initiated with a community or institutional commitment to continue them beyond their research stage or unless the projects involve a change in the health services of the area as detailed above.

Review of Federal facilities

The Senate bill provides that when a health systems agency is requested by or on behalf of a Federal department or agency to review a proposed use of Federal funds to support the development of institutional health services intended for use in the health service area, the

health systems agency shall, within 60 of receiving a request, submit its views on such a proposed use to the Federal department or agency involved and to the appropriate committees of the Congress (section 152).

The conference substitute conforms to the House amendment. Although the conference substitute does not require, as did the Senate bill, a health systems agency, when requested, to review and comment on a proposed use of Federal funds to support the development of institutional health services intended for use in a health service area, the conferees believe that when a Federal agency requests a health systems agency's views on a use of funds proposed by the agency, the HSA should respond to such request even though its response is purely advisory and in no way binding on Federal decision making.

COORDINATION OF HEALTH PLANNING WITH RATE REVIEW

Rate regulation grants

The House amendment contains a provision, not included in the Senate bill, which amends section 1526 by providing that rate regulation grants can be made to any unit in the State which regulates rates although provisions are added to assure adequate coordination with the State planning agency (section 120 (a) and (b)).

The conference substitute conforms to the House amendment (section 120(c)).

COORDINATION WITHIN STANDARD METROPOLITAN STATISTICAL AREAS AND WITH OTHER ENTITIES

Coordination within standard metropolitan statistical areas

The House amendment contains a provision, not included in the Senate bill, which requires that HSA's which are part of a standard metropolitan statistical area shall develop a mechanism to coordinate their plan development and project review functions (section 121).

The conference substitute conforms to the House amendment (section 121(b)).

The conferees intend the required coordination to include the joint review of each health systems plan and annual implementation plan developed for each health service area included within the SMSA, the joint review of criteria used in making reviews affecting the region, and the joint review of each decision under certificate of need which affects the region. Moreover, the conferees would encourage the development of a number of joint activities between or among such HSA's, including joint task forces on the establishment of planning goals for the SMSA, coordination and an intergrated use of data for the SMSA, and joint planning and review task forces.

Coordination with other entities

The Senate bill contains a provision which provides that an HSA will also coordinate its activities with entities which review rates and budgets of health care facilities and with appropriate area agencies on aging, local and regional alcohol abuse, drug abuse, and mental health planning agencies. The State agency is also to coordinate its activities with any entity which reviews rates and budgets of health care facilities (section 122).

The House amendment provides that each HSA and SHCC shall coordinate its activities with any agency which reviews rates and budgets of health care facilities (section 120 (a) and (b)).

The conference substitute conforms to the Senate bill (sections 120 and 121).

COLLECTION AND PUBLICATION OF HOSPITAL CHARGES

Collection and publication

The Senate bill amends section 1513 by adding a new section requiring the States to collect annually, on a form developed in consultation with the State agency, the rates charged for each of the 25 most frequently used hospital services in the State including the average semiprivate and private room rates. The HSA must make such information available to the public for inspection and copying in readily understandable language and in a manner designed to facilitate comparisons among the hospitals in the health service area.

The conference substitute conforms to the Senate bill (section 122(a)).

The conferees note that if a State has an agency which reviews hospital rates then the HSA should work closely with that agency in carrying out this function.

Penalty for not providing information on charges

The Senate bill provides that a State certificate of need program shall provide that no hospital shall be an applicant for a certificate of need unless such hospital has complied with all reasonable requests from an HSA for information needed to comply with the HSA's mandate to collect and publish hospital charges (section 136).

The conference substitute requires that the State administrative program contain provisions to assure compliance with requests for information made by an HSA in carrying out this function (section 122(b)).

STATE HEALTH PLANNING AND DEVELOPMENT AGENCIES

Redesignation or termination of State agency agreement

The Senate bill contains a provision, not included in the House amendment, which provides for the redesignation of State health planning and development agency for up to a three year period, and permits the Secretary the option of either terminating or returning a fully designated State agency to conditional status for a one year period for nonperformance of its functions. After the one year period, the Secretary must either fully designate the State agency or terminate its agreement. Before renewing the agreement, the Secretary shall provide each HSA and the SHCC an opportunity to comment on the performance of the agency. It also provides that the Secretary shall review a State administrative program for health planning not less often than once every three years (sections 131 and 134).

The conference substitute conforms to the Senate bill (sections 123 (a) and ((b)). The conference substitute also provides for the Secretary to enter into agreement with the fully designated State agency for a period of up to 36 months rather than annually as currently provided.

The conferees believe it is unproductive for every State agency to be subject to an annual detailed review and that necessary monitoring of the State agency's performance can be accomplished through regular reporting requirements. However, for those fully designated State agencies which are still expanding or developing their programs, the conferees expect the Secretary to use the designation period of one to two years so that HEW can effectively monitor performance; but, as these State agencies mature and reach an appropriate level of performance, the conferees expect that their designation agreement will be for three years.

Medical facility planning

The House amendment contains a provision, not included in the Senate bill, which repeals the functions required pursuant to section 1513(h) respecting the need for the HSA to make separate recommendations to the State on medical facility projects for modernization and construction. It also adds to the functions required to be performed by the State agency preparation of an inventory of medical facilities located in the State and an evaluation of the physical condition of such facilities. Such determination shall be reported to the HSA's to be used in the preparation of their SHP's (section 122).

The conference substitute conforms to the House amendment (section 123(c)). With this change in law and the requirement that the State health plan be more specific and include resource requirements, the conferees intend that the State health plan serve as the document for medical facilities planning for the State. The requirement for a separate State medical facilities plan as required by Title XVI is no longer needed and is deleted from existing law.

Failure to qualify for full designation

The Senate bill contains a provision, not included in the House amendment, that provides that a State without a designated SHPDA in effect by September 30, 1980 would be subject to a 25 percent reduction in the amount of any allotment of a grant, loan, loan guarantee, or any contract under the Public Health Service Act, Community Medical Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment, Rehabilitation Act of 1980, Such amounts would be reduced by 50 percent if an agreement weren't in effect by September 30, 1981, by 75 percent after September 30, 1982, and by 100 percent after September 30, 1983 (section 132).

The House amendment provides that if a State does not have a fully designated agency upon the expiration of (1) fiscal year 1980; (2) the first regular session of the legislature of the State which begins after the promulgation of regulations under section 117(e) of these amendments; or (3) the sixth month after the month in which such regulations are promulgated whichever occurs later, no grant may be made to or contract entered into with the State with funds authorized by the Public Health Service Act or related Acts (section 122(d)).

The conference substitute as a compromise provides for percentage reductions in the penalty as set forth in the Senate bill which would take effect upon the expiration of (1) fiscal year 1980, or (2) if a legislature of a State is in a regular session on the date of enactment of these amendments, and the legislature will be in session for at least 12 months from such date, or (3) if the legislature of a State is in ses-

sion on the date of enactment but there is not 12 months remaining in such session after such date or if the legislature of the State is not in session on such date, 12 months after the beginning of the first regular session of the legislature beginning after such date, whichever occurs later (section 123(d)).

State agency technical assistance

The Senate bill contains a provision, not included in the House amendment, which requires the State Agency to provide technical assistance in obtaining and filling out the necessary forms to individuals and public and private entities for the development of projects and programs (section 135).

The conference substitute conforms to the Senate bill. Conferees emphasize that the intent in adding this section is not to require the State Agency to prepare an application for an individual desiring a certificate of need or other agency forms, but merely to assist him in understanding the application requirements (section 123(e)).

Extension of State agency conditional designation

The Senate bill contains a provision which would allow a State health planning and development agency to be designated for up to 48 months (section 131).

The House amendment provides that the Secretary may extend the period of conditional designation (now limited to 36 months) for such additional time as he finds appropriate if he finds that the designated State agency is making a good faith effort to comply with the requirements of section 1523 (section 122(g)).

The conference substitute conforms to the House amendment (section 123(f)).

STATEWIDE HEALTH COORDINATING COUNCIL COMPOSITION

Membership

The Senate bill contains a provision, not included in the House amendment, to clarify that consumers and providers of health care included consumers and providers of mental health care for purposes of SHCC composition. It further provides for ex-officio representation of the Veterans' Administration on the SHCC when the State has at least one VA facility (section 138(c)).

The conference substitute as a compromise specifies that the VA shall have ex-officio non-voting representation on the SHCC when the State has at least one VA facility (section 124(c)).

Review of drug abuse

The Senate bill expands the mandate of SHCC review of State plans to include sections 409 and 410 of the Drug Abuse Office Treatment Act (section 138(d)).

The House amendment expands SHCC review of State plans to include section 409 of the Drug Abuse Office and Treatment Amendments of 1972 (section 119(a)).

The conference substitute conforms to the House amendment (section 119(a)).

Representation of medically underserved

The Senate bill provides that members of the SHCC who are consumers of health and mental health care and who are not providers

of health or mental health care must include individuals who are members of rural and urban medically underserved populations if such populations exist in the State (section 138(e)).

The conference substitute requires representatives of medically under served populations on the SHCC (section 124(a)).

Representation of interstate HSA's

The House amendment contains a provision, not included in the Senate bill, which provides that while HSA's, other than interstate HSA's, are to have equal representation on the SHCC, interstate HSA's are to have proportional representation (but at least one representative). It also provides that in States with more than 10 HSA's each may be entitled to one representative (section 123(a)).

The conference substitute conforms to the House amendment (section 124 (a)).

The conferees note that this provision was adopted so that the size of the SHCC can be kept manageable in States which have a large number of HSA's. The conferees which to point out that while HSA's in States with more than 10 HSA's would be entitled to only one representative, this would not preclude the Governor from allowing each HSA to have more than one representative and thereby establishing a larger Statewide Health Coordinating Council.

Selection of State Health Coordinating Council Chairman

The House amendment contains a provision, not included in the Senate bill, which provides that the Governor may select the Chairman of the State Health Coordinating Council with the advice and consent of the State Senate (section 123(b)).

The conference substitute conforms to the House bill (section 124 (b)).

Provider representation

The House amendment contains a provision, not included in the Senate bill, which provides that (*1*) half of the providers represented on the SHCC shall be direct providers, (*2*) members of the SHCC shall represent the provider classifications listed in section 1512(b)(3)(c)(ii), and (*3*) of such members at least one shall be engaged in the administration of a hospital (section 123(c)).

The conference substitute as a compromise specifies that at least one half of the providers on the SHCC shall be direct providers (section 124(c)).

CENTERS FOR HEALTH PLANNING

The Senate bill contains a provision, not included in the House amendment, that requires the Secretary to enter into grants with Centers for Health Planning. In addition, it adds the requirement that centers develop and disseminate methodologies to educate new board members and staff and provide continuing education for present HSA members of the staff and State Agency staff (section 149).

The conference substitute conforms to the Senate bill although both grants or contracts can be used (section 125).

DEFINITIONS

Definitions of HMO

The Senate bill contains provisions, not included in the House amendment, which add definitions of a health maintenance organization to the Act (section 153).

The conference substitute conforms to the Senate bill (section 117).

Definition of medically underserved population

The Senate bill contains a provision not included in the House amendment, which provides that the term "medically underserved population" has the same meaning as such term as under section 330 (b) (3) of the Public Health Service Act (section 153).

The conference substitute conforms to the Senate bill (section 126).

Definition of rehabilitation facilities

The Senate bill defines rehabilitation facilities as any facility which is operated for the primary purpose of providing rehabilitation services to handicapped individuals and which provides singly or in combination one or more of a list of services for handicapped individuals (section 153).

The House amendment defines rehabilitation facilities as an inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons who are in an integrated program of medical and other services which are provided under competent professional supervision (section 117(c)).

The conference substitute as a compromise adopts the definition in the House amendment for certificate of need purposes and defines rehabilitation facilities as an inpatient or outpatient facility for the other purposes of this legislation (section 126).

The compromise provides that a broad definition shall apply to HSA governing board representation, definition of "provider of health care," and inclusion of rehabilitation services in health system agency plans and State health plans. The report adopts the House definition of rehabilitation facility for purposes of certificate of need coverage. The conference committee adopts this compromise with the understanding that any proposed conversion of acute care beds or services to inpatient rehabilitation beds or services by any hospital would require review under a State certificate of need program.

The objective of this compromise is to include both inpatient and outpatient rehabilitation facilities in all phases of the health planning system other than certificate of need which shall be limited to inpatient facilities, including conversion of existing service capacity to rehabilitation usage.

AUTHORIZATIONS

Health systems agencies authorization

The Senate bill provides authorization of appropriations for HSA's at a level of $150,000,000 for fiscal year ending September 30, 1980, $175,000,000 for fiscal year ending September 30, 1981, and $200,000,000 for fiscal year ending September 30, 1982 (section 129(c)).

The House bill provides authorizations for appropriations for HSA's at a level of $150,000,000 ending September 30, 1980, $160,000,-

000 for fiscal year ending September 30, 1981, and $170,000,000 for fiscal year ending September 30, 1982 (section 124(a)).

The conference substitute as a compromise provides for $150,000,000 for fiscal year 1980, $165,000,000 for fiscal year 1981, and $185,000,000 for fiscal year 1982 (section 127(a)).

State health planning authorization

The Senate bill provides for authorizations of appropriations for State agencies at a level of $40,000,000 for fiscal year 1980, $45,000,000 for fiscal year 1981, and $50,000,000 for fiscal year 1982 (section 139).

The House amendment provides for authorizations of appropriations for State agencies at a level of $35,000,000 for fiscal year 1980, $37,000,000 for fiscal year 1981, and $39,000,000 for fiscal year 1982 (section 124(b)).

The conference substitute as a compromise specifies authorizations of appropriations of $35,000,000 for fiscal year 1980, $40,000,000 for fiscal year 1981, and $45,000,000 for fiscal year 1982 (section 127(b)).

Rate review authorizations

The Senate bill provides authorizations of appropriations for rate setting under section 1626(e) of $6,000,000 for fiscal year 1980, $6,000,000 for fiscal year 1981 and $6,000,000 for fiscal year 1982 (section 140).

The House bill provides authorization of appropriations for rate review of $6,000,000 for fiscal year 1980, $7,000,000 for fiscal year 1981, and $8,000,000 for fiscal year 1982 (section 126(e)).

The conference substitute conforms to the Senate bill (section 127(c)).

Centers for health planning

The Senate bill provides authorizations of appropriations for centers for health planning and technical assistance of $6,000,000 for fiscal year 1980, $8,000,000 for fiscal year 1981 and $10,000,000 for fiscal year 1982 (section 149).

The House amendment provides authorizations of appropriations for carrying out section 1534 of $10,000,000 for fiscal year 1980, $11,000,000 for fiscal year 1981, and $12,000,000 for fiscal year 1982 (section 125(d)).

The conference substitute as a compromise specifies authorizations of appropriations for the support of activities under section 1534 $6,000,000 for fiscal year 1980, $8,000,000 for fiscal year 1981, and $10,000,000 for fiscal year 1982 (section 127(d)).

Area health services development fund

The Senate bill contains no authorizations of appropriations for the area health services development funds.

The House amendment contains authorizations of appropriations for the same purpose at a level of $25,000,000 for fiscal year 1980, $40,000,000 for fiscal year 1981, and $50,000,000 for fiscal year 1982 (section 125).

The conference substitute as a compromise provides $20,000,000 for fiscal year 1981 and $30,000,000 in fiscal year 1982 (section 127(e)).

TECHNICAL AMENDMENT

Percentage of HMO enrollees

The House amendment contains a provision amending section 1903 (m) (2) (c) of the Social Security Act to allow a health maintenance organization three years from the time it is qualified to meet the requirement that at least 50 percent of an HMO's enrolled population be made up of other than Medicare and Medicaid recipients (section 126).

The conference substitute conforms to the House amendment (section 128).

Miscellaneous amendments

The Senate bill contains a provision, not included in the House amendment, which repeals section 314 (a), (b) and (c) and Title 9 in its entirety.

The conference substitute conforms to the Senate bill.

Report on effectiveness of planning law

The House amendment contains a provision, not included in the Senate bill, which specifies that the Secretary shall report to the Congress on the results of the review conducted pursuant to Section 1535 respecting improvements in health and health care and restraints on increases in health care costs (section 125).

The conference substitute conforms to the Senate bill.

EFFECTIVE DATES

The Senate bill provides that amendments to Title XV shall take effect on the date of enactment of this Act, except that certain amendments shall take effect one year from the date of enactment and other amendments shall take effect six months from the date of enactment except that on or after the date of enactment, the HSA's, the State Agencies, and the SHCC's, may make the organizational and related changes required and may act in accordance with the changes in their functions made by such amendments (section 157).

The House amendment provides that certain amendments shall take effect one year after the date of enactment except that on or after the date of enactment, the changes in membership of the HSA's and the SHPDA's shall be implemented through selection of members to fill vacancies occurring after such date, except that the HSA (the State Agency and the SHCC may make the organizational and related changes required and act in accordance with the changes in their functions at any time. Changes in certificate of need requirements become effective 180 days after enactment except when a change in law is required in which case a longer period is allowed (section 127).

The conference substitute conforms to the House amendment (section 129).

The conferees note that the changes in the HSA funding provisions are not effective until the Congress has adopted an appropriation for fiscal year 1980.

Title II—Revision of Authority for Health Resources Development

REVISION AND EXTENSION OF ASSISTANCE

Approval of medical facilities plan

The Senate bill contains a provision, not included in the House amendment, which requires the Governor as well as the SHCC to approve the State Medical Facilities Plan (section 201).

The conference substitute conforms to the House amendment.

Repeal of allotment grants

The House amendment contains a provision, not included in the Senate bill, which repeals Part B of Title XVI, the Part which provides allotment grants to States for facility construction and sets forth requirements for the State medical facilities plan (section 201).

The conference substitute conforms to the House amendment (section 201(a)).

Loan fund capitalization

The Senate bill contains a provision, not included in the House amendment, which authorizes additional capitalization of the loan fund in any fiscal year through 1981 (section 203).

The conference substitute conforms to the Senate bill 201(b)).

Purposes of loan and loan guarantee authorizations

The House amendment contains a provision, not included in the Senate bill, which restructures the loan and loan guarantee provisions of section 1620 to provide assistance for projects in the following priority areas:

1. modernization of medical facilities;
2. construction of new outpatient medical facilities;
3. construction of new hospitals in (a) areas of rapid population growth or (b) areas where mergers or closure of medical facilities results in a reduction of new beds; and
4. conversion of existing medical facilities, outpatient medical facilities, or facilities for long term care (section 201(b)).

The Senate bill contained similar provisions.

The conference substitute as a compromise provides that the loan fund may be used to support projects for (1) the discontinuance of unneeded hospital services or facilities, (2) the conversion of unneeded hospital services and facilities to needed health services and medical facilities, including outpatient medical facilities and facilities for long term care; (3) the renovation and modernization of medical facilities, particularly projects for the prevention or elimination of safety hazards or the avoidance of noncompliance with licensure or accreditation standards, or projects to replace obsolete facilities; (4) the construction of new outpatient medical facilities and (5) the construction of new inpatient medical facilities in areas which have experienced recent rapid population growth (section 201(b)).

Interest subsidies

The Senate bill provides that the Secretary may pay to the holder of a loan amounts sufficient to reduce up to one-half of the net effective interest rate otherwise payable on the loan if the Secretary finds that

without such assistance the project could not be understaken (section 207(d)).

The House amendment provides that the Secretary shall pay the holder of any loan amounts sufficient to reduce by 3 percent per annum the net effective interest rate otherwise payable on the loan if the project is located in an urban or rural poverty area (section 201(b)).

The conference substitute as a compromise provides that the Secretary may pay the holder of a loan an amount sufficient to reduce by not more than one-half the net effective interest rate if the loan is located in an urban or rural poverty area (section 201(b)).

Loan guarantee support for public entities

The Senate bill contains a provision, not included in the House amendment, which would allow the Secretary to guarantee the loans of non-federal lenders to public entities in addition to non-profit private entities (section 207(b)).

The conference substitute conforms to the Senate bill (section 201(b)).

Grant support to nonprofit private entities

The House amendment contains a provision, not included in the Senate bill, which would allow grants to be made under section 1625 to nonprofit private hospitals. This section authorizes grants for construction or modernization projects to eliminate imminent safety hazards and avoid noncompliance with licensure and accreditation standards. Existing law limits grants to public medical facilities (section 201(c)).

The conference substitute as a compromise restricts the eligibility of private non-profit medical facilities for such grants. The conferees intend to permit only those private non-profit medical facilities to be eligible for grants which can demonstrate that they serve their community in a capacity similar to that of a public hospital. The conferees adopted three criteria for this determination: the demonstrated level of community service; the proportion of patients served who are unable to pay for such services themselves or through third party reimbursement; and the impact on services to low-income individuals if the grant were denied. These eligibility criteria are to be used in addition to the other criteria currently used to determine the award of grants under section 1625.

The conferees intend that "level of community service" refer to the well-established definition of that phrase under the Hill-Burton program, and not be interpreted as simply a measure of the relative poverty level of the local population.

The conferees also intend that the lack of access to a public hospital be considered by the Secretary as part of the impact on services to low-income individuals criteria in determining eligibility for grants under this section.

Authorization for grants for modernization

The Senate bill provides authorizations of appropriations under section 1625(d) modernization of public hospitals of $40,000,000 in fiscal year 1980, $50,000,000 in fiscal year 1981, and $50,000,000 in fiscal year 1982 (section 204).

The House amendment contains authorizations of appropriations of $50,000,000 for each of those three fiscal years (section 201(c)).

The conference substitute conforms to the Senate bill (section 201(c)).

Outpatient medical facilities

The House amendment contains a provision, not included in the Senate bill, which establishes a project grant program for the construction of outpatient medical facilities in medically underserved areas and the conversion of existing facilities into outpatient medical facilities or facilities for long term care. A grant could be awarded for up to 80 percent of the cost of such projects and 100 percent of the costs of such projects located in urban or rural public areas. Fifteen million is authorized for each fiscal year from 1980, 1981 and 1982 for this purpose (section 201(c)).

The conference substitute conforms to the House amendment except that no funds are authorized for fiscal year 1980 (section 201(c)).

Continued availability of funds under section 1625

The Senate bill contains a provision, not included in the House amendment, which provides that funds appropriated in fiscal year 1976 for medical facility construction under section 1613 but not yet expended may be available through fiscal year 1980 to carry out the purposes of 1625(d) which provide grants to public hospitals for the modernization and construction to meet life and safety code violations (section 202).

The conference substitute conforms to the Senate bill (section 201(c)).

TECHNICAL AND CONFORMING AMENDMENTS

The House amendment contains a provision, not included in the Senate bill, which adds conforming and technical amendments to Title XVI (sections 202 and 203).

The conference substitute conforms to the House amendments (sections 202 and 203).

Title III—Program to Assist and Encourage the Discontinuance of Unneeded Hospital Services

ESTABLISHMENT OF PROGRAM

The Senate bill would establish a program under which financial assistance would be provided to hospitals for the discontinuance of unneeded hospital services and the conversion of unneeded hospital services to services needed by the community. Under the program debt payments, incentive payments, and conversion payments would be provided for the discontinuance of all inpatient health services or an identifiable unit of a hospital or an identifiable part of a hospital which provides inpatient health services. Funds appropriated for this program could also be used by the Secretary of HEW to make grants to State health planning and development agencies for planning, evaluating, or carrying out programs to decertify health care facilities providing health services which are not appropriate.

The House amendment would establish a program under which grants and technical assistance would be provided to hospitals to assist and encourage them to discontinue all hospital services or of an inpatient hospital service by converting an identifiable part of a hospital

facility to the provision of other health services. The House amendment would also make separate authorization of appropriations for the Secretary to make grants to State health planning and development agencies to assist such agencies in addressing the problems of excess capacity reduction.

The conference agreement conforms to the House amendment with the following changes.

1. Grants and technical assistance may also be provided for the discontinuance of an identifiable part of a hospital facility.

2. The hospital's application to the Secretary shall include reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on a project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931, and the Secretary of Labor shall have with respect to such labor standards the authority and functions set forth in Reorganization Plan numbered 14 of 1950 and section 2 of the Act of June 13, 1934.

3. In determining the need for any service or services proposed to be discontinued or converted by an applicant, a health systems agency and State agency shall give special consideration to the unmet needs and existing access patterns of urban or rural poverty populations.

The conferees note that there have been numerous suggestions that the health planning program deal with the problem of excess capacity by adding a mandatory decertification authority to the existing mandate for certification of the need for proposed new institutional health services. The approach envisioned in this bill, however, is purely voluntary in nature and depends for its success on the cooperation of both providers and planning agencies. The conferees also note their concern that the voluntary incentives could create the situation in which some communities might be tempted to close politically or financially vulnerable services such as those provided by a public general hospital. Similarly, during the past several years private hospitals located in low income inter-city neighborhoods have either transferred their facilities to outlying suburban areas or established satellite facilities in suburban areas which then drain needed resources away from inter-city communities. Such closures or phase outs deny access to needed services by the poor and minorities and can be particularly devastating if the clinics or departments involved are the source of scarce emergency or outpatient services. The conferees intend that the guidelines and priorities of this program are such that they assure that the facilities and clinics needed by the poor and minorities for inpatient and outpatient care are not discontinued unless adequate provision for alternative facilities and clinics are made available. The conferees have agreed to permit grants to be used to discontinue the provision of an identifiable part of a hospital facility so that, for instance, an entire wing of a hospital may be taken out of service. This authority is not to be used to discontinue an identifiable service unit, such as one of four operating rooms.

The conferees recognize that the closing of unneeded facilities and services will affect many employees. In requiring the hospital discontinuing services to make fair and equitable arrangements to protect the interests of employees, the conferees intend for the hospital to protect

employees against a worsening of their positions respecting employment. This means that the hospitals should make a reasonable effort to obtain comparable employment for affected employees and should substantially preserve the rights achieved by the employees. The Secretary of Labor should describe the issues which hospitals must address in making fair and equitable arrangements, and is expected to actively encourage and foster adequate protection for all employees affected by grants under this section.

Grants to States for reduction of excess hospital capacity

The Senate bill authorizes the Secretary to make grants to SHPDA's for planning, evaluating or carrying out programs to decertify health care facilities (section 205).

The House amendment contains a provision which authorizes grants to States for the purpose of demonstrating the effectiveness of various means of reducing excess hospital capacity. Such grants would assist SHPDA's in identifying excess capacity, informing the public of its costs, and developing a program to reduce excess capacity in a way that provides the greatest savings in the cost of health care delivery. Four million dollars is authorized for each of the next three years (section 118(b)).

The conference substitute combines the two approaches in new section 1643. Support for SHPDA's under this section would be limited to 10 percent of the amount appropriated under new section 1644 (section 301).

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